Compiled Report of

Community Based Monitoring of Health Services Under NRHM in Maharashtra

(2007-2010)

SATHI

State nodal NGO for Community Based Monitoring of Health Services in Maharashtra

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March 2010

Dr. Dhananjay Kakde

With inputs from other SATHI-CEHAT team members and District nodal NGOs

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Preface

Assisting community initiatives to access improved public health services as a right has been a key theme of the SATHI team's work since its inception. Moving towards establishing the Right to Health care by strengthening the public health system while making it accountable, has been a major objective of the broader Jan Swasthya Abhiyan network since its formation through a nationwide campaign in the year 2000. With this larger context, health activists and certain people's organisations had taken pioneering initiatives for community monitoring of health services in specific districts of Maharashtra. Hence the launching of Community based monitoring under NRHM in mid-2007, as an outcome of sustained people-oriented advocacy by health activists and decisions by enlightened NRHM officials, was welcomed by civil society organisations in Maharashtra, as it was in many other states. This initiative was viewed as a significant opportunity to deepen, broaden and make sustainable processes for community accountability of health services and establishment of health rights.

However, this has been a unique 'social experiment', where for the first time such community accountability, feedback and dialogue mechanisms in the health sector were to be systematically implemented on a significant scale within spaces supported by the public health system. The challenges of 'getting on board', a wide range of social and official actors, of dealing with potential conflicts in a creative manner was a daunting one. Added to this was the challenge of managing in a timely manner a wide range of activities through a chain of collaboration and capacity building stretching from national to block level, and of ensuring that these activities would lead to concrete improvements to maintain the momentum of the process.

As the following pages would show, these challenges unfolded as the process developed; many of the problems could not have been predicted beforehand and were dealt with as they emerged. The fact that despite such myriad challenges, the first phase of Community based monitoring could be implemented with considerable effectiveness in Maharashtra, incorporating significant innovations and creative additions, is a testimony to the commendable drive of all the participating NGOs and people's organisations, to the cooperation given by public health officials at state level and health functionaries at other levels, and most importantly the enthusiasm of countless community members across the state who made the entire activity possible.

Three years is too short a time span to make a definitive evaluation of such a complex process which is still in its emergent stage. It is even more difficult to predict the future course that this process will take, as it is being generalised to larger numbers of districts and villages. However, what may be surmised is that a sound beginning has been made to a challenging and exciting journey. In the first phase areas, steps have been taken to restore

people's confidence in the public health system and many significant improvements have appeared. However, to sustain the momentum of the process and the enthusiasm of community members, it is essential that health system improvements expand to become all encompassing, and that these improvements are sustained. Combined with this, the incipient attitudinal change among health functionaries and authorities at various levels, of whom many now have greater willingness for equitable dialogue with people and openness to accountability processes, needs to be deepened much further and must become integral to their functioning. Now that people's expectations have been raised, it is the collective responsibility of all actors involved in the process to ensure that these genuine expectations not be frustrated, but are rather increasingly satisfied by effective, equitable and accountable health services.

This short report attempts to document some of the key processes and activities during the first phase of Community based monitoring in Maharashtra. Reflecting the highly collaborative nature of the community monitoring process itself, this booklet is the result of the combined efforts of a large number of persons associated with this activity. The principal drafting of the entire booklet has been done by Dr. Dhananjay Kakde, Associate coordinator of SATHI-CEHAT, who has devoted major amount of time and energy in writing and refining successive drafts of this report. He has diligently incorporated various editorial and content related suggestions given from my end. We have gratefully acknowledged the crucial contributions of the wide range of collaborators and participants in this process in a separate section.

However in conclusion we must mention the efforts devoted by countless ordinary community members, who among other things participated in meetings and trainings, offered various forms of information, helped fill report cards, attended Jan sunwais and other public events - thus ensuring that the entire monitoring activity was genuinely and truly 'community based', and thus made this report possible.

Dr. Abhay Shukla,
Coordinator, SATHI- CEHAT, Pune

Acknowledgements

On behalf of SATHI we would like to express our sincere gratitude to the following organisations and individuals who have contributed in many ways in making this report possible-

- **The District nodal NGOs** and **District coordinators** from the five pilot districts of the state, as well as the **Block nodal organisations, Block coordinators and facilitators** who collected, shared and provided most of the information which is reflected in this report.
- **Brendan Donegan** and **Supriya Kumar** for the process documentation done by them during the pilot phase in Thane and Pune District respectively.
- **Samrat Shirwalkar** for facilitating media coverage of the CBM activities.
- **Prashant Khunte** for contributing his insights to 'Dawandi' while shouldering the editorial responsibility.
- **Sangeeta Gandhe** and **Vandana Kulkarni** for doing process documentation of first and second round of State culmination and review workshop respectively.
- **Anupam Dayal** and **Kerry Scott** for doing editing of some sections in the report.
- We acknowledge the contribution of **NRHM, Government of India** for its financial and administrative assistance to the community monitoring process, and in particular the advice and support extended by **Shri Amarjeet Sinha.** We gratefully acknowledge the role played by the **Advisory Group for Community Action** and specifically its national secretariat comprised of **Population Foundation of India** (PFI) and **Centre for Health and Social Justice** (CHSJ) in facilitating this entire activity.
- Here we would further like to acknowledge the continued positive inputs given by **NRHM, Maharashtra officials** in facilitating the entire community monitoring process in the state. The contributions of **members of the State Mentoring committee** in shaping this process are also acknowledged.

Within the SATHI team-

- **Dr. Nitin Jadhav, Ashwini Dorwat, Trupti Joshi, Shailesh Dikhale, Shakuntala Bhalerao, Shweta Raut,** and other SATHI team members played a key role by sharing their experiences of implementing the process and facilitating English translation of Marathi process documentation.
- **Deepali Yakkundi** and **Anjali Kale** carried out the analysis of data with great patience in the pilot phase. **Deepali Yakkundi** played a central role in analysis of data from all three rounds of monitoring.
- **Dr. Abhijit More** for analysis of data on medicine availability in PHCs across three rounds of monitoring.
- **Sharada Mahalle** painstakingly formatted and prepared the copy of revised report for printing. We would like to acknowledge the entire **Administration staff of SATHI** for their valuable cooperation.
- We thank **N.R. Enterprises** for printing this report in time.

Contents

INTRODUCTION

The National Rural Health Mission (NRHM) was announced in April 2005 by the United Progressive Alliance Government to realise the promises made under the Common Minimum Programme. NRHM was launched with a view to bring about improvement in the health status of the rural population, mainly by strengthening the public health system with a strong focus on Primary Health Care.

In the NRHM 'Framework of implementation', decentralized planning and community participation are strongly advocated. Similarly NRHM proposes an intensive accountability framework through a three pronged process of external surveys, stringent internal monitoring and an innovative approach of community based monitoring of health services.

One of the most significant health policy initiatives under NRHM has been introduced in the form of such a comprehensive framework for community-based monitoring and planning at various levels of the Public Health system. Perhaps for the first time in India, such an intensive accountability framework for the Public Health institutions has been introduced by the Government in a generalised manner[1]. It has been expected that this provision would allow community members and beneficiaries, with support from community based organizations/NGOs working with communities, to actively and regularly monitor the progress of NRHM interventions in their areas. Besides ensuring accountability, it would also promote decentralized inputs for better planning of health activities, based on the locally relevant priorities and issues identified by various community representatives.

Further it was felt that unlike many other NRHM interventions which would be implemented by the State health department, community based monitoring of health services would require certain kinds of special, additional facilitation. This activity is to be organised with active involvement of communities and can be achieved only with the active participation of all stakeholders including the ultimate beneficiaries, the service providers, and various NGOs and people's organizations (POs) working for health rights. The issue of facilitation of CBM was discussed in the meeting of the Advisory Group for Community Action (AGCA)[2]. AGCA believed that CBM is an innovative activity with many aspects not yet completely worked out, and hence before introducing this programme at the national scale, a demonstrative pilot would be necessary to draw critical lessons from small scale implementation in selected states of the country.

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[1] National Rural Health Mission- Meeting people's health needs in rural areas (Framework of implementation 2005- 12)

[2] AGCA is a group of experts especially constituted by the Union Health Ministry to get technical and other inputs for implementing NRHM programmes wherever community action is envisaged.

Similarly there was a consideration that the pilot phase would be crucial to build an initial critical mass to promote this innovative activity, and would help create a pool of expertise which would be crucial for the scaled up phase of community based monitoring[3]. Based on these considerations, the proposal to develop the process of community monitoring under NRHM, as a demonstrative pilot in the first phase was formulated and presented by the AGCA to NRHM (Union Ministry of Health and Family Welfare) officials for consideration.

From May 2007 onwards, the Union Ministry of Health and Family Welfare in consultation with the AGCA, initiated this national pilot in the following states: Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu. The state of Karnataka was subsequently added to the list of pilot states.

Objective of this Report

In the state of Maharashtra, the pilot phase activities of community based monitoring were completed by end-2008. After that Maharashtra was the first state in the country to include the CBM component of NRHM in its State Project Implementation Plan (PIP), making the state health department a very important stakeholder in this process[4]. From Dec. 2008 onwards this process has been financially supported by the State Government, based on NRHM funds. Undoubtedly experience gained in the pilot phase has helped all stakeholders in reformulating the strategies of implementing CBM in the ongoing scaled up phase. This has been reflected in successive PIPs, particularly those for 2009-10 and 2010-11.

The objective of this report is to highlight critical lessons learnt from the first phase, as well as insights from the scaled up phase. With this objective, the focus of this report is to outline -

a. Activities for implementing the project: successes and challenges.
b. Innovations introduced during the process of community monitoring.
c. Findings emerging from CBM and impact of CBM.
d. Possible Strategies while Further Scaling up the CBM Process.

In addition, this report also briefly mentions the structure and processes of CBM (as mentioned in the implementation manual), so that basic information about the first phase is available to all readers.

[3] Proposal to facilitate on a pilot basis Community based monitoring of Health services under NRHM

[4] The first phase tended to be perceived as a civil society initiative by the State Health Department, however their level of ownership has progressively increased.

Historical context of community based monitoring of health services in the state of Maharashtra - Before official recognition of the process of CBM as part of NRHM, in the state of Maharashtra and also in Madhya Pradesh some people's organisations had organized activities for community accountability of health services. Although these activities were confined to specific areas, these experiences offered some valuable insights to the drafters of the outline of CBM. It should be noted that to an extent some of the core strategies of the CBM that are mentioned in the NRHM implementation framework are definitely influenced by these insights.

In the year 1999-2000, the Union Health Ministry supported a project 'Empowering the Rural Poor for Better Health' where two of the pilot blocks were from Maharashtra (Dahanu in Thane district and Pachod in Aurangabad district). Here Kashtakari Sanghatana's experience of community monitoring using 'Village health calendars' in Dahanu was a useful input for later efforts. Similarly, Jan Sunwai, a potent tool for social audit of health services, was used by Adivasi Mukti Sangathan (Madhya Pradesh) in 2003 and by Kashtakari Sanghatana in Dahanu in 2004. In both these areas, the SATHI team was involved in partnering with people's organisations and giving various technical inputs. In a way, these events provided certain elements for the framework of community based monitoring of health services. The preparatory and follow up activities of Jan Sunwais were among the early systematic efforts towards communitising the agenda of Health Rights. On a broader scale, Jan Swasthya Abhiyan (People's Health Movement - India, a nationwide coalition of civil society organisations working on health issues) had organised a series of Public Hearings on the Right to Health Care in collaboration with the National Human Rights Commission in 2004.

I.
The Organisational Evolution of Pilot Phase and Expansion Phase of Community Based Monitoring in Maharashtra

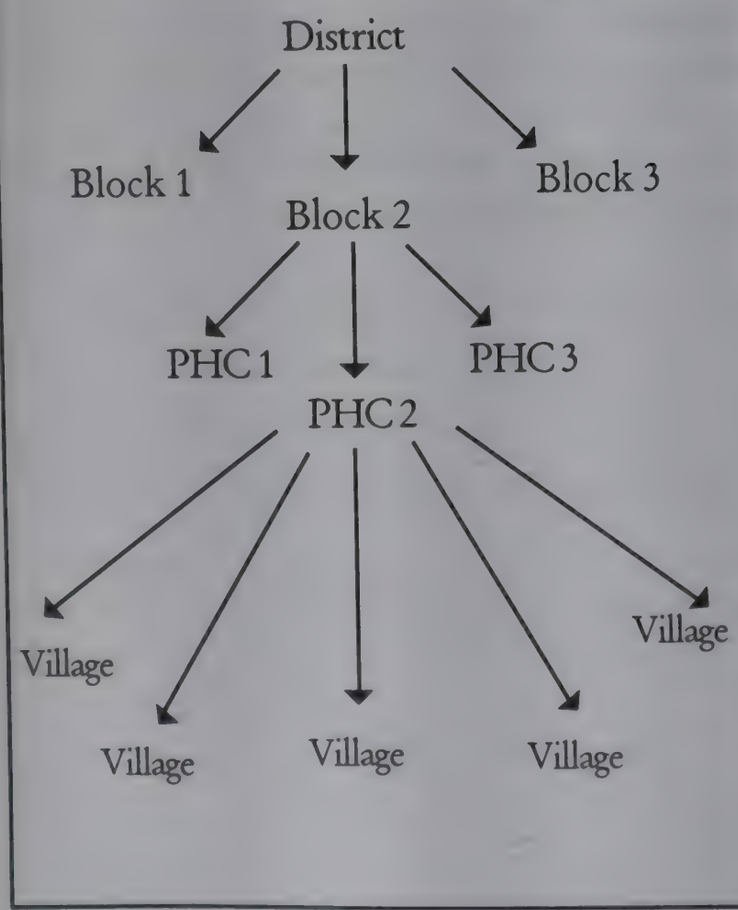
This section of the report briefly describes the evolution of the frame work of CBM activities in the two phases of this process, and is divided into two parts-

A. The pilot phase (May 2007 to March 2009)

B. The expansion phase (April 2009 onwards)

A. The pilot phase of community based monitoring -

Structure of pilot within a district



As mentioned above, in the state of Maharashtra five districts were selected for implementation of this project in five regions of the state. In each district three blocks, and in each block three primary health centres (PHCs), were selected. Similarly, under each PHC, five villages were selected to implement the project. Thus in each district, 3 blocks, 9 PHCs and 45 villages were selected to implement the project. This pattern of implementation was adopted across all pilot states.

Overall scale of implementation in pilot phase in Maharashtra- Total number of districts- 5, Total number of blocks- 15, Total number of PHCs- 45, Total number of villages- 225.

A. Selection of districts and formation of State Mentoring Committee

In the AGCA it was decided that in the every pilot state, a team of two AGCA members would make a visit to facilitate the process of selection of pilot districts, and would also orient the state level senior officials about the process of monitoring,. They would also be initiating a process of formation of the state mentoring team in the respective pilot states.

For the state of Maharashtra two AGCA members - Dr. Abhay Shukla and Dr. Shyam Ashtekar were designated to initiate the process. Accordingly in May 2007, Dr. Shukla met the Principal Secretary, Health of Maharashtra Ms. Chandra Iyengar along with the Director, Health Services and the Mission Director, NRHM. In this meeting the following districts were agreed upon to implement the pilot project: Pune, Osmanabad, Nandurbar, Thane and Amaravati. Although according to national criteria, only four districts were 'sanctioned' for Maharashtra, a fifth district was proposed and later accepted by the Union Health Ministry, due to the strong suggestion from the state government that this was necessary to cover all regions of the state. These districts were selected on the basis of representation of various regions and the presence of civil society organisations which could anchor community monitoring within the district. Out of the five districts that were selected Thane, Nandurbar and Amaravati districts are predominantly tribal districts and have been in the news for last many years for malnutrition related deaths. Pune district has better socio-economic indicators and presumably people here have somewhat better access to health care. Osmanabad is a comparatively backward district of the drought-prone Marathwada region of Maharashtra. All these districts have a presence of civil society organisations working in the Health sector with a rights based approach.

In the same meeting with the Principal Secretary, the names of the persons from the voluntary sector and from the government who would constitute the state mentoring committee were also finalised. This committee has been responsible for taking strategic decisions and overseeing the implementation of the process in the state.

In our understanding this programme in the initial phase has been generally perceived as an 'NGO initiative' by the state authorities, and unlike the rest of the NRHM initiatives, the center to state information sharing about this programme was comparatively weak.

The broad functions of the State Mentoring Committee were as follows-

a. Selection of state and district nodal NGOs.

b. Technical guidance and support to the state nodal NGO in implementing the project.

c. Specific facilitation of the pilot project with the state government, a forum for discussion and decision-making, involving both government and NGO representatives

Members of the state mentoring team were selected based on their experience of health related work at the grass root level and ability to give inputs to the process of community based monitoring.

Members of the state mentoring team in Maharashtra-

From civil society organisations- Dr. Shashikant Ahankari, Dr. Ashok Dayalchand, Dr. Satish Gogulwar, Ms. Manisha Gupte, Ms. Sudha Kothari, Ms. Anjali Kulkarni, Dr. Anant Phadke, Shri. Bhim Raskar, Dr. Abhay Shukla. The state mentoring team was later extended, with Dr. B.S. Garg and Shri Brian Lobo included as new members.

The State health department representatives- Principal Secretary, Health; Secretary and Commissioner, Family Welfare; Director of Health Services; Director, NRHM.

The first meeting of the state mentoring team in Maharashtra took place on 7th June 2007, in Pune. In this crucial meeting important decisions regarding finalization of the state and district nodal NGOs, process for constitution of committees in pilot villages, and at PHC, block and district levels were taken. Based on the discussion in this meeting, SATHI-CEHAT was selected as the state nodal NGO. Similarly, in five pilot districts of the state, on the basis of consensus within NGOs from each district attending the state workshop and certain selection criteria[1] the district nodal NGOs were selected.

Based on the selection criteria following organisations were selected as the District Nodal NGOs and Block Nodal NGOs to implement the pilot project in five districts-

District nodal NGOs - Amaravati- KHOJ; Osmanabad- Tata Institute of Social Sciences; Nandurbar- Janarth Adivasi Vikas Sanstha; Thane- Van Niketan; Pune- MASUM.

Block Nodal NGOs-

1. **Pune- Purandar block-** MASUM; **Velha block-** Rachana- Society for Social Reconstruction; **Khed block-** Chaitanya
2. **Nandurbar- Shahada block-** Janarth Adivasi Vikas Sanstha; **Dhadgaon block-** Narmada Bachao Andolan; **Akkalkuwa block-** Lok Sangharsh Morcha
3. **Amaravati- Paratwada block-** Khoj Melghat; **Dharni block -** Apeksha Homeo Society; **Achalpur block-** Mamta Bahudeshiya Society
4. **Osmanabad- Tuljapur block -**Halo Medical Foundation; **Osmanabad & Kalam blocks-** Lokpratishthan
5. **Thane -Murbad block-** Van Niketan; **Jawhar block-** Dr. Manibhai Desai Adivasi Mahila Sangh; **Dahanu block-** Kashtkari Sanghatana

[1] Ref- Screening Civil Society Organisations for involvement in the Community Monitoring- AGCA proposal.

Formation of District mentoring teams

Similar to the State mentoring committee, in every pilot district a District mentoring team was constituted to support the implementation of the project. The District mentoring team was expected to carry out specific facilitation with the district health authorities, ensure the quality of district and block nodal NGOs interventions, and scrutinize the periodic reports prepared by the District nodal NGO.

B. The expansion phase of community based monitoring

Selection of nodal organisations in new districts in the expansion phase-

As already mentioned after the pilot phase was concluded, CBM has been extended to eight new districts of the State. For selection of nodal organisations in these districts the following procedure has been followed-

1. State government published an advertisement in newspapers in April 2009

The State health department has published an advertisement in the regional newspapers seeking expression of interest from potential organisations to facilitate this project. Eligible NGOs were asked to apply to the State Nodal NGO within 15 days of the advertisement backed up with requisite documents.

2. Main criteria for selection of organisations and formation of screening team to scrutinize applications of organisations

Main criteria decided for eligibility of District nodal NGOs were -

- Registered organisation working on health issues at community and block level since at least 3 years.
- Documented experience of some type of community monitoring or social audit of Health services or other social programmes.
- Documented experience of training of community based functionaries on health issues. In exceptional cases training experience in other social sectors may also be considered as relevant experience.
- Preferably experience of organizing Jan Sunwais or similar mass programmes for public accountability.

SATHI as the state nodal NGO has prepared a format for screening of applications. For the purpose of screening of applications, a team was formed at the State level which comprised of three members from the State health department and one member from the State nodal NGO. This team shortlisted a few applicants from each district, based on the scores they received according to the screening format.

3. Formation of Joint appraisal team and field visits to the offices of shortlisted organisations

The objective of forming the Joint appraisal team was to interview each shortlisted organisation and to assess its administrative capacities and relevant experience of social audit or rights based work. The assessment criteria and format were largely decided by the State nodal NGO and State NRHM officials.

The following organisations were selected by the appraisal teams to implement Community based monitoring in eight new districts for the expansion phase-

Solapur- Halo Medical Foundation, **Beed**- Manavlok (Marathawada Navnirman Lokayan), **Aurangabad** - Marathawada Gramin Vikas Sanstha, **Kolhapur**- Sampada Gramin Mahila Sanstha (SANGRAM), **Nashik**- VACHAN (Voluntary Association for Community Health and Nature), **Raigad**- CFI (Children Future India), **Gadchiroli**- Aamhi Amchya Aarogyasathi, **Chandrapur**- Yard Sanstha

Some key observations from the selection process

1. Unlike the pilot phase where the State mentoring team and the State nodal NGO were centrally involved in selection of potential organisations in the pilot districts, the situation has changed in the expansion phase. In this phase the State health department was centrally involved in deciding selection criteria for organisations and in the actual shortlisting as well as appraisal of organisations. There was significant administrative delay in finalizing the selection criteria and also in informing district officials about the selection procedure.
2. The State Health department has received more than 400 applications from eight districts, however the majority of organisations were found to be inexperienced concerning rights based work and lacking required background to conduct an activity like community monitoring.
3. Inspite of categorical instruction in the advertisement that any attempt to do canvassing would lead to disqualification, some organisations have attached recommendation letters from political leaders, and in some cases people involved in the selection process received 'request' phone calls from interested organisations.

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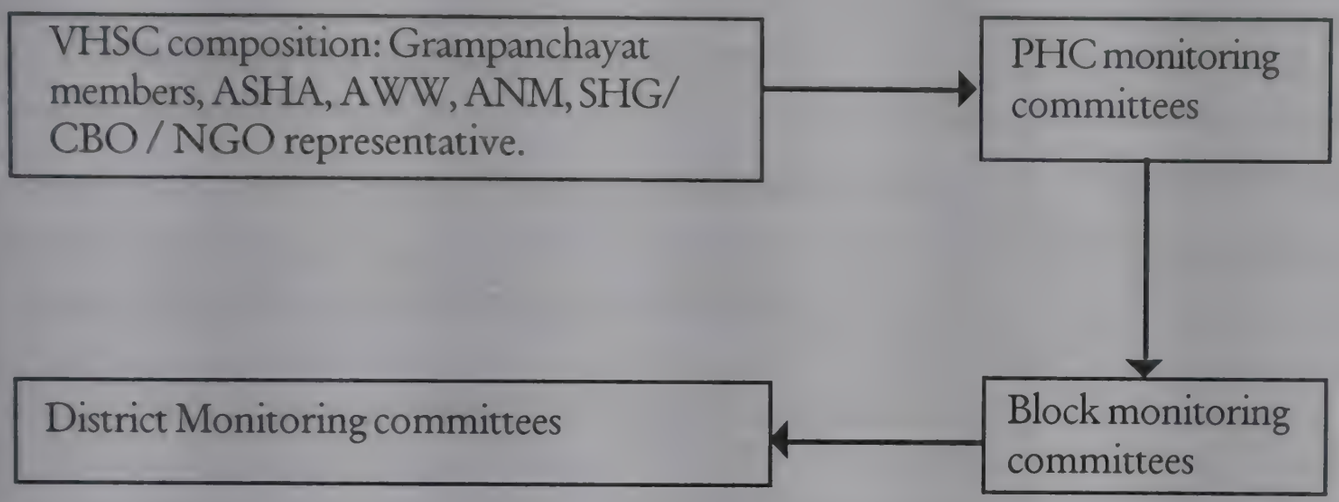
II.
Organisational Structure of Community Based Monitoring of Health Services

A. Plan of implementation in the state of Maharashtra-

Structure and composition of the monitoring committees



***General composition of the monitoring committees (PHC onwards)** - 30% Panchayati Raj Institution representatives, 20-30% Health officials, 20% CBO / NGO representatives, 15-20% non-official delegates from lower committees, 10% Rogi Kalyan Samiti representatives in block and district committees. Chairperson - from Panchayati Raj Institution. Executive chairperson - health official. Convenor - from CBO / NGO.*

The method that was adopted for constituting the monitoring committees has been quite different compared to the usual practice of forming higher level committees first. Here the sequence of constituting the monitoring committees was from the village level to the district level.

B. Broad activities of the monitoring committees -

Level	Activity
Village	a. Reviews village health register, village health calendar b. Reviews performance of ANM, MPW, AWW, ASHA c. Sends brief three monthly report to PHC committee.
PHC	a. Reviews and collates reports from all VHSCs b. Members visit PHC, review records, discuss with RKS members c. Send brief three monthly report to block committee.
Block (including rural hospital (RH))	a. Reviews and collates reports from all PHCs b. NGO / PRI sub team visits at least one PHC of the block, conduct interviews with medical officer (MO) and make observations c. Members visit community health centre (CHC) and review records d. Send brief three monthly report to district committee.
District (including district hospital)	a. Reviews and collates reports from all blocks b. An NGO / PRI sub team visits at least one CHC of the district, conducts interviews with Incharge, meets block committee members and RKS members, makes observations c. Members visit district hospital and reviews records, discuss with RKS members d. Send brief three monthly report to state committee.

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III.
Processes of Facilitation and Capacity Building

This section of the report is divided into three parts-

A. State level workshop and Training of Trainers

B. Workshops and trainings in pilot districts

C. State level workshop on community based health planning

One of the key components of the pilot phase is 'trainings on CBM' at all levels of the monitoring committees. In fact this was the most challenging and demanding activity in the spectrum of activities completed in the pilot. In the following pages we have attempted to give a brief summary of various training activities. Key learnings are mentioned at the end of the each important activity.

A. State level workshops and training of trainers

1. The state workshop-

This workshop was held in Pune on 7th and 8th June 07. The objective of the state level workshop was to detail out all processes of monitoring and orient all stakeholders (state mission officials, district health officials and PRI representatives from selected districts, NGO networks and civil society organizations from pilot districts) about the CBM. It was expected that after this workshop the CBM processes would be rolled out across all the pilot districts.

Our expectation of the state workshop was to ensure that the state authorities would initiate processes for institutional acceptance and responsiveness for this programme at all levels of the public health system, starting from the state to PHC level. However, barring one or two higher officials in the state health department, initially response to this initiative was mainly passive.

2. The State ToT-

Maharashtra state level Training of Trainers (ToT) on Community Based Monitoring was held during 7th to 11th August 2007 in Pune. In this training, district coordinators and block facilitators, who were also expected to act as master trainers in respective districts, were trained in the skills and tools that would be required in CBM. In the same training session, they were also informed about related aspects of NRHM, with specific emphasis on

the service guarantees. On the second day of the training, DHS Maharashtra and Director, NRHM came to participate in a session on the role of monitoring committees and coordination among various committees as panelists. Other sessions conducted in this training were-

a. Role and responsibilities of various committees for CBM at the village, PHC, block & district level.
b. Role and responsibilities of the state nodal agency, district nodal agency, block level NGOs, district, block, coordinators, block facilitators.
c. Indicators for monitoring and tools.
d. Role of Health Department in CBM formation of committees and outline of trainings at various levels.
e. Fieldwork to learn about application of tools for collection of data.

In this training, the tools were shared with the trainees, on which in depth discussion took place amongst the participants and some modifications were suggested in the tools. On day three of the ToT a specific session on field testing and finalization of the tool was conducted.

Groups of facilitators went to villages in Purandar, Haveli and Khed Talukas of the district.

Key observations from the State ToT-

1. Five days of rather exhaustive training, in terms of duration, becomes 'heavy' for participants and it becomes difficult to maintain high levels of concentration until the end.
2. The group of trainees attending the state level ToT had varied background and capacities. Some of the participants who were present as trainees had some previous experience of monitoring health services. There was a perception by a few participants that information shared during the ToT was occasionally too basic.
3. One concrete suggestion that came from one of the district coordinators after the state ToT is as follows- a questionnaire could be administered to a subset of the village community based on a statistical sample size so that inferences can be made about the entire village. Structured interviews can also be administered in relatively little time, allowing VHSCs to rapidly finish collecting data from a statistical sample. She says, however, that this research-oriented view is not shared by all NGOs involved in the CBM process.

4. Even when the state level ToT was underway, some uncertainty prevailed about the tools being used for training. In retrospect, presenting draft tools for finalization in the ToT was not the best strategy. Some participants clearly expressed that one day of field work to test and finalise tools is definitely inadequate. However the intention of doing so was to get adequate feedback from all civil society organisations involved in the process and make the process genuinely participatory.
5. Capacity building of the block coordinator and facilitator requires separate and well defined process, since they will be directly interacting with the community at the village level. During the block ToT it was observed that, though many of them were present for the state ToT, still there are critical gaps in their understanding.
6. There was a suggestion that instead of five days, a three day state ToT might suffice, however the duration of the district ToTs should be increased[1].
7. In the structure of CBM it is mentioned that the district ToT would be conducted by the district and block coordinators. However in reality in the pilot phase a significant amount of hand holding and technical support needed to be given by the state nodal NGO.

B. District level workshop and trainings in the pilot districts

In each pilot district the sequence of activities was as follows-

i. District level workshop.
ii. District level ToT
iii. VHSC trainings.

i. District level workshops-

The objective of the district level workshop was to share the concept of CBM with key district health officials, PRI members and civil society organisations. However ensuring simultaneous presence of the DHO, ADHO and the Civil Surgeon was often a difficult exercise for the district nodal NGOs.

In the district workshop, district coordinators and the resource persons of the state nodal NGO explained the structure of CBM and also outlined issues on which cooperation of the district, block and the PHC level officials would be required. In the same meeting, government officials also shared their views about the process of community based monitoring of the health services.

[1] Keeping in view the need for more training, in fact duration of the district trainings was increased from 1 day to 3 days.

Key issues observed in the district workshops-

a. There seems to be a general pattern in responsiveness of district health officials across all pilot districts, but if **co-operation is not mandated from the top then it becomes a low priority and seems to be optional.** Hence just like other health programmes in this case too the response and support to this initiative and all other district level activities was mainly 'evoked' through government resolutions (GRs) and similar orders from top.

b. In general all officials who attended the district workshops were till then unaware of the process of CBM.

c. However in some district workshops, certain concrete suggestions came up, which helped the district nodal NGO in prioritising district specific issues for monitoring. For example in one district it was discussed that Anganwadis need to be monitored more carefully. However the monitoring framework suggested for Anganwadis was not sufficient hence more indicators would be required.

d. In every district workshop, the resource persons were sure to mention that until that workshop, planning had been done only by the administration. They informed workshop participants that there had previously been no official channel for feedback from the community, which could be incorporated in the planning process. With CBM, the community is being given a considerable role in planning.

e. Press releases were circulated on launching of CBM activity during district level workshop in Thane and Nandurbar district, resulting in significant coverage by newspapers.

f. Although PRI members were invited to all district workshops, except in Osmanabad, in no other district PRI members were present for this workshop.

ii. District level ToTs-

Each district workshop was followed by the training of block facilitators at the district level. From two districts, even after changes were made to..., it was reported that there were some discrepancies in the modified tools. The state nodal NGO then made some corrections in tools keeping in view this suggestion. In some places the district level workshop was sequentially combined with the district level ToT.

The block facilitators trainings were held in two stages. In the first round (often contiguous with the district workshop) the main issues covered were basic information about NRHM, peoples' rights under the NRHM and services guaranteed, the role and composition of VHSCs and training of VHSCs. Keeping in mind the fact that all skills necessary for block facilitators and coordinators could not be covered effectively in one go, a second round of trainings was held later covering the tools for village and PHC monitoring, and the filling of report cards.

Key issues observed during the district level ToTs-

a. In every pilot district, the VHSC trainings were supposed to be conducted by the block coordinator and facilitators. One general pattern that we have observed in the district ToTs, was varying degree of capacities amongst the selected block facilitators to relate with health issues. The difference between understanding of some facilitators who had previous experience working on health issues and freshers who had no such experience was clearly perceptible.

b. In one of the district ToTs, one day of the training was reserved for field work, so that trainers would get first hand experience of tools and monitoring methods. Block facilitators were very good at adapting information on monitoring that they learned during the ToT for the villagers. They not only were able to communicate messages in the local dialect but also tailored these messages to the local social context. However they were seen to be less adept at negotiating with the health system and functionaries.

c. One critical issue that emerged in the second round of trainings of block facilitators and coordinators, around the time of VHSC trainings, was the transmission loss. Transmission loss is understood as the information that fails to reach trainees down the line in a cascade training model. Though this is expected to be a problem in any large scale cascade model, it was clearly seen by resource persons who went to conduct the second round of trainings before the VHSC trainings.

d. Many of the block facilitators had never been trainers before. These block facilitators often felt unsure of themselves when conducting even the functional VHSC trainings. At such places the block coordinator and the district coordinator played an important supportive role.

C. State level workshop on Community Based Health Planning

Besides ensuring accountability through participatory monitoring, at the core of Community based action is the process of informing the local health planning process by identifying locally relevant priorities. After completion of the pilot phase and three rounds of data collection, it was felt that in five pilot districts the present dominant mode of planning of health services, where there is very little community participation, needs to be qualitatively changed by facilitating more decentralized inputs. Keeping in view this broader perspective, a two day State level Community Based Health Planning workshop was held in Pune on 5th and 6th April 2010. This workshop was attended by representatives of all district and block nodal NGOs from the five first phase districts. As resource persons Dr. P. Doke (Executive Director- SHSRC, Maharashtra) and Dr. Abhijit Das (CHSJ- Delhi and AGCA member) contributed to this workshop.

On the first day of the workshop, concepts like decentralized planning in the health sector as envisaged in the NRHM documents, rights based people centered planning for health were discussed in depth. Similarly representatives of the participating organisations shared their experiences of the existing non-participatory and top-down process of District Health Planning. Similarly significant brainstorming was done about the existing spaces for participatory planning at the village, block and the District level and constraints in using these spaces. One of the key sessions on first day was about the district and block level information sources and other secondary sources which could be used for the process of health planning. This session was conducted by Dr. Doke, based on his three decades long experience of public health administration he quite effectively enlisted the critical bottlenecks in the process of planning. This helped participants in understanding present mode of planning and key processes where intervention would be needed. Remaining two sessions on the first day were conducted by Dr. Abhijit Das who discussed concepts, tools and methods for participatory planning. In this session, participants were oriented to tools like Participatory rural appraisal and Community needs assessment techniques. Most of the participants found this session very useful for next day when they were actually supposed to brainstorm about the planning process for their respective areas.

On the second day of the workshop, free listing of key issues, preparation of planning matrix and block level resource mapping was conducted, based on group exercises for respective districts. At the end of the workshop, representatives from various groups discussed the tentative plan of action for implementing the community based health planning process during the coming one year.

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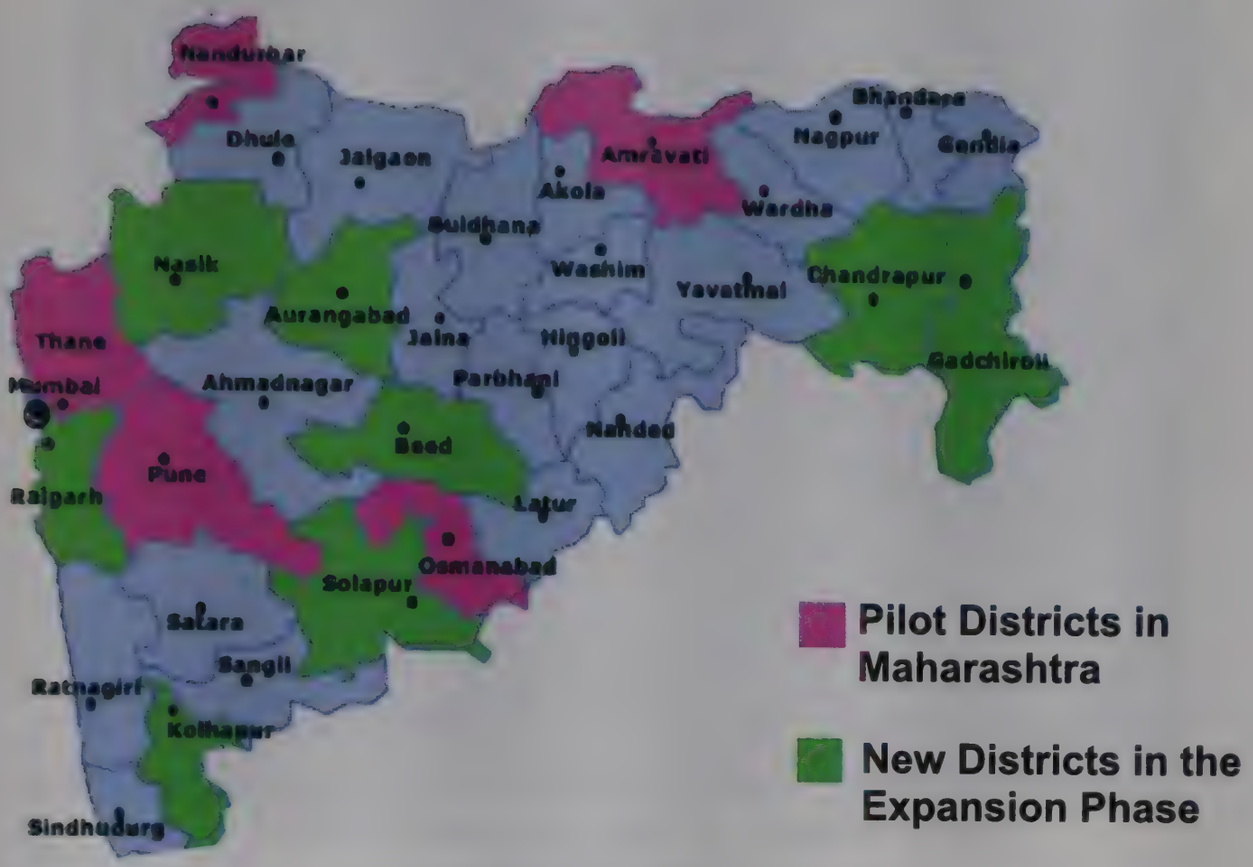

Blocks in each Pilot District

1) Nandurbar
- Shahada
- Akkalkuwa
- Dhadgaon

2) Amaravati
- Achalpur
- Chikhaldara
- Dharani

3) Thane
- Jawahar
- Murbad
- Dahau

4) Osmanabad-
- Osmanabad
- Kalamb
- Tuljapur

5) Pune-
- Purandar
- Velhe
- Khed

New Districts in the Expansion Phase

1) Solapur
2) Beed
3) Aurangabad
4) Kolhapur
5) Nashik
6) Raigad
7) Gadchiroli
8) Chandrapur

Public hearing at Saswad rural hospital in Pune District

VHSC Members examining stock of medicine in PHC

Community Monitoring of Anganwadi in Thane District

VHSC members testing water sample in Amravati District

Thane District- Jan Sunwai

Village Level Meeting for expansion of VHSC in Dhadgaon Block in Nandurbar District

IV.
Community Mobilisation, Formation and Training of the Monitoring Committees in Pilot Phase

In the CBM framework, the sequence of forming the monitoring committees is in form of a 'reverse cascade', i.e. committees are formed from the base upwards instead of the standard practice of forming the higher committees first. (Hence the sequence of forming committees is VHSC → PHC → Block → District → State monitoring committees). In the first phase districts involved in the CBM process in Maharashtra, monitoring committees have been formed up to the district level and the process for forming the State monitoring committee has been initiated but is pending decision from state level authorities.

a. Community mobilization and formation of the VHSCs

A process of raising awareness of community members regarding their health entitlements and the significance of community monitoring was carried out in all villages, prior to formation / expansion of VHSCs. At least three meetings in the village were conducted for this purpose, and the final meeting was expected to be in the form of an 'official' Gram Sabha where the new VHSC members would be selected and formation / expansion of the VHSC would be declared. Posters related to people's health entitlements under NRHM were put up in the village as part of this process.

As discussed in the following box, innovative strategies for community mobilization were adopted by people's organisations in Thane district.

Fostering Community Participation and Mobilisation - Innovative strategies used in Thane District

Arogya Jagruti Diwas- (Health Awareness Day)

In the framework of community based monitoring it is suggested that in every pilot village meetings should be held to raise awareness about health entitlements and to facilitate community mobilization. This guideline was followed by all programme implementing organisations in entire state. However in Dahanu block of Thane district a further innovation in form of organizing 'Arogya Jagruti Diwas' (Health Awareness Day) was introduced by the implementing people's organisation. As Brian Lobo of Kashtakari Sanghthana puts it, 'the objective behind this initiative was to get all sections of the people interested and involved in this programme and also to create ownership of the programme beyond VHSC members'. On Arogya Jagruti Diwas, community members collected in large numbers (generally between 50 to 150 people) and were informed about their entitlements in public health facilities, responsibilities of the outreach health functionaries and also the role they

have to play in the process of community monitoring. The occasion of Arogya Jagruti Diwas was also used to undertake some constructive work like cleaning a well or digging soak pits, such collective activity is a crucial community level process to strengthen solidarity amongst community members around health issues. This collective process was followed by the collection of information necessary for filling the village report card, and then filling the report card as a public activity. Of course this activity was carried out after the VHSC had been trained, enabling VHSC members to participate in filling the report card.

Considering the present response to CBM, in hindsight it seems that the strategy of Arogya Jagruti Diwas worked very well.

'Open' trainings and block conventions -

In Dahanu and Murbad blocks the Village Health and Sanitation Committee trainings were open for not only the VHSC members but also other interested community members. There were some VHSC trainings that were attended by more than 50 people. According to Deepak Abnave, district coordinator of Thane 'this innovation has definitely created a facilitative environment that promoted high social recognition of the programme'. Similarly in all blocks of Thane district, block conventions were held at an early stage involving all stakeholders in the process, i.e. community members, PRI members, taluka medical officers and other public health functionaries. This has improved coordination amongst all stakeholders and also resulted in expediting the block level monitoring processes.

In the section on "Institutionalising community led action for health" in the NRHM implementation framework, it is stated that the VHSC would be formed in each village within the overall framework of the Gram Sabha. In these committees proportionate representation from all hamlets and adequate representation to the disadvantaged categories such as women andSC/ ST would be given. There have been various situations encountered regarding the actual experience of formation of VHSCs in 225 pilot villages in Maharashtra. Some such issues are discussed in the following box.

Key issues observed during the formation of the VHSCs-

a. One of the first challenges in Maharashtra was that in most of the pilot villages, already the VHSCs had been officially constituted. However, when concerned NGOs enquired about these VHSCs, in most villages it became evident that only the Sarpanch (who is the elected leader of the Gram panchayat) and the Anganwadi worker-who together are joint signatories for the village untied fund-had been named, but no other members had been identified. Hence based on this feedback, the State Health Department was asked to issue a separate, special order for expansion of such committees with clear mention that the local CBOs (like women's savings groups) and civil society representatives should be given representation while expanding the existing VHSCs.

b. At the initial stages, the response of the PRI members to be a part of the VHSC and to get involved in the monitoring function was very passive. However in some areas, after VHSC members/local NGOs arranged repeated personal meetings with them, they became convinced that community based monitoring was a worthwhile endeavour. Yet, generally participation of the PRI members in the monitoring process was quite low and it has not gone beyond attending VHSC training sessions in some pilot blocks.

c. During the process of expansion of VHSCs, it was considered desirable to organise Gam Sabhas, where the names of additional members would be finalised. However, given the time constraints, poor cooperation from Gram Sevaks and lower participation of Panchayat members in several places, this was not possible in many villages. Hence expansion took place based on smaller village level meetings and consultation between civil society representatives and Sarpanch / Gram Sevaks in most villages.

d. In the structure of CBM, the suggested PRI constituent members of the VHSC are SC/ ST and women representatives, with a suggested guideline that the women representative could be the chairperson of the VHSC. However it seems that in majority of places, the officially designated chairperson of the VHSC, appointed before the CBM process started, is the Sarpanch. The reason behind this could be the fact that the untied fund of Rs. 10,000 entitled to the VHSC is deposited in the name of the Sarpanch and the Anganwadi sevika, hence most villages seem to have defaulted to appointing the Sarpanch as the head of the VHSC.

e. One of the innovative strategies for involving the PRI representatives in the process of monitoring is making them aware of the political impact that could be achieved through the process of monitoring. This strategy has been effectively followed in a few pilot blocks in Maharashtra. One such experience has been documented in Velhe Block of Pune District- activists of the block nodal NGO have managed to mobilize PRI members effectively to play an active role in VHSCs. Such mobilization was largely not seen in other pilot districts of Maharashtra.

b. Formation of the PHC monitoring committees -

Formation of the PHC monitoring committees has been completed, yet a key factor responsible for prolonging this process has been the significant delay in issuance of the Government Order for the formation of PHC, block and district monitoring and planning committees. After the decision to issue the order was taken and a detailed relevant draft was submitted, it further took about six months to actually issue the order.

However, it should be noted that without waiting for the order, in some districts the PHC committees were informally constituted based on the composition given in the available draft order. These were finalized after the issuing of the order.

i. Training of VHSCs -

Despite a common format at the state level, there have been variations in the length of the VHSC training sessions across the state. In some places this training was conducted in one day while at other places it lasted for more than two days. In these trainings, VHSC members were informed about the public health system with emphasis on the entitlements in the National Rural Health Mission, the tools for monitoring and the process of filling the village health report card. As evident from the structure of CBM, the VHSCs are at the core of all community monitoring activities. Obviously major efforts were taken at the national and the state level to design the tools for monitoring and methods to be adopted for the VHSC trainings.

The strategic objective of the VHSC trainings, in the context of CBM, could be summarized as follows-

a. To inform and empower the VHSC members for performing their monitoring function by collecting health care related information at the village level.

b. To motivate VHSC members to play a proactive role in the monitoring and planning of village health services.

c. To enable VHSC members to effectively disseminate information in the community about the entitlements as promised by NRHM at the community level.

It is important to mention here that the Marathi guidebook that the state nodal NGO prepared for the block facilitators in Maharashtra, was designed keeping in view these general objectives.

Key issues emerging from the VHSC trainings-

a. From almost all pilot districts it was reported that the block nodal NGOs were forced to cancel initial trainings because of poor attendance by VHSC members. Then they changed the strategy and individually invited the VHSC members. As the district coordinator of Pune mentions- "People had to be individually invited - this happened typically for the last training session in any taluka - before we could see a significant increase in the number of VHSC members attending. The NGO realized this on its own and started inviting members individually after the first two training sessions were poorly attended."

b. Attendance of the VHSC members in the training sessions was variable across the state. However, participation was better in pilot villages where the implementing agency already had a history of community level work. .

c. These trainings were supposed to be conducted by the block facilitators; however almost all district coordinators have reported that in order to maintain quality they have personally attended several VHSC trainings and have conducted key sessions. In retrospect, it seems that for obvious reasons district coordinators were not very sure of technical competency of the newly oriented block coordinators and facilitators to conduct these trainings.

d. In some places, these trainings were also attended by the ANM and AWW. However, regarding the monitoring/evaluation tool, ANMs have complained that the questionnaire being used for monitoring their work gave more importance to tasks that they considered to be of lower priority and did not cover their work adequately. For example, some ANMs felt the questionnaire overvalued the treatment of minor ailments rather than immunization camps).

e. We noticed that in general there was comparatively low turn out of official health functionaries (e.g. ANMs, MPWs) for the range of VHSC and district trainings on community monitoring. Probably this has something to do with trainers who have a NGO or CBO background, who might overlook existing work overload and genuine difficulties that ANM / MPW may face while doing outreach functions. Moreover, the method of communicating the core content of these trainings might have been perceived by the local health functionaries as an imposition of another top-down initiative.

f. Significant delays in releasing funds from the national level led to a delayed start of the important activity of VHSC trainings. The resultant gap between formation of the VHSCs and their training might have had some adverse impact on active participation of the VHSC members.

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V.
Adaptations and Development of Training Material and Tools for Monitoring

During the complex activity of community based monitoring of health services, while maintaining a basic common framework, we have seen variations in styles of intervention across various districts and blocks of Maharashtra. These are primarily because of the uniqueness of different communities, varying socio political situations, local health profile specificities, differing characteristics of the civil society organisations involved in monitoring, and variable state of the public health system. Thus strategies have to be tailored to specific contexts, not only because health care needs of the people vary, but also because perceptions of the people and their capacities to participate in health programmes also vary. That is why the CBM process is not centrally driven and has considerable scope for adaptation keeping in view the state and district level specificities.

For example in Maharashtra, pictorial monitoring tools and report cards were prepared for pilot districts with low literacy level.

Apart from the adaptation in the training material and tools, a large number of posters and pamphlets were developed for wide dissemination at the community level.

Developing pictorial version of monitoring tools based on requirement expressed from Thane district- In Thane district with majority adivasi or tribal population, literacy is low, especially among women, and most of the VHSC members were tribal women. The standard questionnaire and report card tool for CBM has the limitation that it requires a certain level of literacy to understand it. During VHSC training, it was realised that VHSC members were having difficulty understanding the questionnaire and report card tool because of limited formal education, and therefore there was a concern expressed by representatives of people's organisations that they would not be able to use it properly. To make it easier for VHSC members to understand and use the questionnaire and report card tools, a pictorial version was developed and the phrasing of questions in the tools was modified.

For each question in the questionnaire, a picture was drawn to accompany the question. In addition, the categories of 'Full Roti', 'Half Roti' and 'No Roti' were used instead of the original variety of categories for responses: '2', '1' and '0' for most questions. It was also felt that the villagers would not be able to understand what was meant by 'disease surveillance', and it was decided that 'disease surveillance' should be changed to something the VHSC members would be able to understand, and which other villagers would be able to relate to their experience, and argue about in a jan sunwai. For this reason 'disease surveillance' was replaced by 'services of MPW' in Maharashtra. Similarly, 'curative services

at village level' was replaced by 'services of ANM'. Subsequently it was realized that there is a problem with these changes, which is that it focuses personal attention on the performance of MPWs and ANMs - that is, it 'points the finger' at them, when arguably ANMs are the most vulnerable and over-worked in the public health system. Indeed, ANMs were present in many of the arogya diwas/arogya din observed in Thane district (MPWs were often not present because in many places there is no MPW appointed), and it was apparent that they perceived the section of the questionnaire and report card that dealt with 'services of ANM' as a personal critique of themselves: they became defensive and sometimes attempted to influence the marks awarded by the villagers and/or VHSC.

Keeping this experience in mind it was realised that the terms 'disease surveillance' and 'curative services' were consciously used in the original questionnaire and report card as terms that could refer to certain aspects of the work of the MPW and ANM without naming these health workers. Now in further monitoring, these categories have been rephrased to avoid association with specific health workers; simple yet non-personalised terms should be used which would enable the VHSC and villagers to conduct monitoring in a less threatening manner.

The pictorial modification has definitely helped less educated VHSC members and activists, who were able to use this tool to understand the focus of each question and therefore were able to contribute to the process.

Preparation of the Marathi implementation manual for the block facilitators and coordinators-

The prototype of the implementation manual was prepared by the NRHM National Secretariat with the help of experienced persons. However it was felt that this material would require some adaptation while translating it into Marathi. After doing a range of modifications in this material the Marathi manual was published in February 2008.

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VI.

Process of Data Collection and Report Card Preparation at the Village and PHC Level

At the time this report was compiled, three rounds of monitoring at the village and PHC levels had been completed. The first round of data was collected in July-Aug. 2008, the second round in March-Apr. 2009 and the third round in Oct.-Dec. 2009. This section is an attempt to share key observations made during the data collection at the village and PHC levels.

This section of the report is divided into following subsections-

a. Indicators on which the data is collected.
b. Group discussion, facility survey, exit interviews and interview of the MOs.
c. Limitations of tool and challenges faced during the data collection.
d. Changes done to the process of data collection in 2nd and 3rd round of data collection

a. Indicators on which the data is collected.

In the implementation manual of CBM, indicators on which the information would be collected have been clearly spelt out. **Almost all indicators for collection of information are based on the service guarantees stated in the NRHM implementation framework.** In the pilot phase, indicators for information collection at the village level and the PHC level were finalized, and accordingly tools for monitoring were formulated. It was also decided that frequency of the monitoring cycle in every village would be once in three months i.e. Report card of village would be prepared once in every three months and submitted to the PHC monitoring committee.

Information was collected in the village level report cards on the following parameters	Information was collected in the PHC level report cards on the following parameters
a. Disease surveillance services b. Maternal and child health services (ANC, PNC and immunisation) c. Curative services at village level d. Anganwadi services e. Availability of services and quality of care available at PHC f. Utilisation of village untied fund.	a. Infrastructure- Electricity, water supply, toilet facility, labour room, indoor facility, laboratory facility. b. Services- Delivery services, referral services, indoor services, laboratory services. c. Availability of Human resources- MO, ANM, lab technician, driver etc.

g. Adverse outcomes (Denial of health care, maternal death, infant death)	d. Availability of essential drugs- Stock of nine high priority essential drugs checked based on the state guidelines on minimum availability. e. Exit interview of patients - Quality of service, behaviour of providers, corruption etc.

b. Group discussion, facility survey, exit interviews and interview of the Medical Officers.

In each monitoring cycle at the village level, two group discussions were planned. One of these group discussions was with the general community including men, and one was exclusively with women. Similarly, at the PHC level, exit interviews of the OPD patients were to be conducted in each cycle. These group discussions and exit interviews were accompanied by a facility survey at the PHC and interview of the PHC MO.

Facility surveys were mainly conducted by the block coordinators. It should be noted that some of these surveys were also conducted by the VHSC members as stipulated in the official structure. However, the PHCs where VHSC members have done the facility survey were limited to two blocks in Thane district.

Similarly exit interviews and interview of MOs in the pilot phase were also conducted by the block facilitators or coordinators. It seems that significantly more capacity building of the VHSC members will be required before they can perform somewhat complex tasks like the exit interviews and the MO interview.

Process of group discussion at the village level-

- For the group discussions with the community, generally around 15 to 20 community members were present. However, at some places exclusive meetings with women in the village were not conducted. It appears from the reporting that facilitators have seriously attempted to hold group meetings in the Dalit/ Adivasi hamlets of the village.
- After describing the objective of the meeting and detailed discussion on the service guarantees that are offered in the NRHM, the process of the community monitoring was explained to community members.
- Participants were asked about disease surveillance, curative services provided by outreach functionaries and the utilization of the untied fund and responses were recorded in a form of rating on a scale of 0, 1 and 2 (bad, unsatisfactory and good). People responded to most of the questions. However, across all pilot villages people were usually simply unaware of the untied fund.

- Once the meeting was over the responses were recorded in the above mentioned 0 to 2 format and each response is scored. The corresponding score was written in the column named 'Score'. Finally after tallying the scores and sum total was entered in the score column. (Ref- Score card in the villages).

c. limitations of the tool and observed challenges during data collection -

In the NRHM framework, apart from the internal MIS and the external evaluation, as a system for validation of data ' Community Monitoring' has been suggested as the third leg of the monitoring system. It seems that policy makers have assumed that the community monitoring would generate data. In retrospect there is a scope to believe that this consideration has also influenced the way in which the CBM has been structured and unfolded at the community level.

During the pilot phase there was a genuine attempt to create a shared model of Community Monitoring processes to promote community led action in the field of health. Yet some degree of ambiguity still persists about way the community monitoring has been perceived by various stakeholders. Within the programme implementers both NGOs and Peoples organisations have collected data in Maharashtra, there seem to be shades of emphasis on various aspects of the process. People's organisations want CBM to be implemented in a way that it should trigger community action, with more emphasis on communitisation of monitoring agenda than the data generation, and they filled the report cards often as a public exercise. Whereas NGOs, though they have also taken efforts to initiate community action, were clearly more focused on the processes of systematic data generation and compilation of the report cards.

Some limitations of the process of collecting information -

As already mentioned in the structure of CBM, the methodology for collecting information at various level of the Public Health System is based on questionnaires (broadly mentioned as tools for monitoring). These tools are by and large based on the services guarantees promised under the NRHM. Some of the perceived limitations of the processes of information collection and tools are as follows-

1. At the start of the village level Group Discussion, the person who was conducting it, was suppose to share information about the NRHM and service guarantees. It was assumed that this preparatory activity, would be essential to make participants aware about the service guarantees. Apart from general awareness about the NRHM and related entitlements, objective of this preparatory activity was also to prepare community to answer the monitoring questions objectively. However in some of the pilot areas this information was shared rather technically and generally was limited to the NRHM and entitlements. Ideally it should have been

contextualized keeping in view the state of locally available health services and relevant issues associated with it. Perhaps this was the reason why Group Discussions were less effective in some of the pilot villages.

2. In some cases, when the block coordinator visited a village he or she was unable to find any beneficiaries who had had a recent first hand experience of the health service of interest, such as immunization. In these situations, gathering information on this service has been difficult. Although in the implementation framework it is mentioned that interviews of such beneficiaries should be ensured along with the group discussion, in reality this was not possible every time.

3. Keeping in view the data analysis component in the CBM structure, most of the questions are specifically formulated to seek answers according to fixed options (Good / Partly satisfactory / Poor). In theory the block coordinators and facilitators were advised to also write down additional information about the existing health system, which is beyond the questionnaire and still relevant, in a form of short narration. In reality, this has seldom happened.

4. Persons conducting the group discussions have to be aware of common public health terminology. One episode that outlines this need has been documented in a pilot village in Pune district-

5. *"There had been no maternal death in the past three months (in the village), but there had been a premature delivery (six months) resulting in the death of the infant. There had also been a case of a woman who was registered at Bharti Hospital and was on her way there in a tempo when she had her child. Then, instead of going to the hospital, she came home. The child died within 10 days. Rachana noted this as one, rather than two cases of infant mortality in the village* - **it needed to be clarified with them that the death of an infant, even if born prematurely, is indeed a case of infant mortality".** (This correction was possible because the person doing the process documentation was aware of the correct definition of the term "infant mortality." It seems that instances like the one mentioned above might go unreported.

6. From the point of analysis of data, fixed responses were found to be easier to analyse, hence there are no open ended questions in the questionnaire. Since information gathering was limited to the questionnaire, not always all critical experiences that people have about the health system are reflected in the monitoring findings. There has to be some rethinking about how the information collection could allow for open ended questions and qualitative responses on issues of specific concern to the community.

"How should you score the data when half the group answers in the affirmative and the rest disagree?" Pune District coordinator.

Some interesting observations about the tools for community based monitoring-

One of the recurring themes during the pilot phase of community based monitoring has been the appropriateness of suggested tools for monitoring. In fact in the period between the state level ToT and the VHSC trainings, a range of modifications were suggested in the tools. Some of the observations of participants during the trainings are as follows-

- "They [the block coordinators] are not researchers. They are village-level karyakartas. Giving them new information repeatedly confuses them. They have to be trained carefully to conduct exactly the activities required." District Coordinator.
- "For us community action would be more important than the data collection" - Representative of a people's organisation.
- "You should include open ended questions in tools, our final objective should be to know people's perception and not filling a questionnaire"- Representative of a people's organisation.
- "There should be space and a system to document the discussions that take place among villagers in response to questions. For example, in one village, an MPW was reported to be checking the quality of water that was available from the hand pump, but not of the water in the well. Currently, this detail would be lost to documentation, and there would be no way for the VHSC to follow up with the MPW regarding this in subsequent quarters."- Process documentation CBM in Pune.

In summary, this dilemma about the tools as the monitoring method and its impact on the monitoring processes was vividly captured in the process documentation of CBM processes in Thane District-

"It can be said that where POs have been involved in CNM at block level, they have exhibited a different attitude towards the process than NGOs. NGOs are concerned to complete the tasks allotted to them 'by the book' (i.e. as instructed by district level, state level or national level nodal agencies) and as quickly as possible. POs are more concerned that the process should involve active participation from as many community members as possible, and that the process should involve community members trying to ensure the accountability of government health officers - rather than an organisation, PRI or the VHSC acting on their behalf. This difference in attitudes can be understood in terms of the question: **Is the main purpose of CBM to get the community to gather data about health services, or to actively involve the community in monitoring provision of health services?** Many NGOs seem to feel that gathering data is the priority, whereas the POs of Thane district feel community action is more important. The innovations introduced in Thane district were made possible because the State nodal NGO has shared this view and supported the PO."

d. Modifications in the process of data collection in second and third round

After the pilot phase of community based monitoring was completed, the tools for community based monitoring were modified and certain new sections have been added to the monitoring process, keeping in view field level experiences. Key changes are as follows-

i. There is now a separate section of questionnaire for collecting information from the VHSC members, besides community level processes like group discussions and beneficiary interviews.

ii. There is separate section to evaluate the pattern of utilization of the village level untied fund.

iii. The entire questionnaire dealing with Anganwadi services has been substantially revised.

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VII.

The Jan Sunwais

Jan Sunwai (Public hearing on health services) as a tool to improve locally available public health services and to raise accountability of health functionaries is not an entirely new strategy. However, perhaps for the first time, Jan Sunwai as an integral activity for the public health system has been included in the official framework, as part of community based monitoring. Obviously, in most places, this official mandate has helped the implementing organisations to ensure the presence of relevant government officials in these hearings. This provision has been quite effectively used as a forum for accountability by implementing organisations and the community itself. A diverse range of issues have been raised during Jan Sunwais, including: availability of medicines, availability of medical personnel at the service point, ambulance services, irregularities observed in the provision of incentives, corruption and illegal charging, attitude of the service providers, instances of denial of health services and a number of policy related issues.

Mobilising for a Jan Sunwai is always challenging, and it is even more challenging to productively manage this event. The conflict and resentment that a Jan Sunwai can trigger between civil society organisations and government officials can be significant, hence it is always crucial to ensure that the Jan Sunwai does not lead to a breakdown of dialogue. However, as a strategy, Jan Sunwais were found to be very useful tools for community mobilization and awareness generation. In Maharashtra, in most places, despite some occasional acrimony during the event, Jan Sunwais have had a definite positive impact on services and behaviour of staff. In the national structure of CBM it was mentioned that Jan Sunwais would be organized at PHC and block levels. However in Maharashtra after the PHC public hearings, in order to involve the district level officials who are better placed to address various systemic issues, instead of block level the hearings were held at the district level.

A. PHC level Jan Sunwais

In all during the first phase, 42 Jan Sunwais were held at the PHC level. In Purandar block of Pune district, instead of PHC Jan Sunwais, 'Jahir Arogya Sabhas' were organised in each village covered by CBM. These hearings were mostly organized in the period July to September 2008. It should be noted that at some places, in order to ensure the presence of officials for this event, instead of the slightly confrontationist term like 'Jan Sunwai', the term 'Jan Samvad' (meaning 'Public dialogue' in English) has been used by the implementing organisations.

In the second phase, 45 PHC level Jan sunwais were organized in the period Nov. 2009 to Jan. 2010. It was observed that the number of issues as well as the sharpness of complaints was generally reduced in the second phase of hearings compared to the first phase.

Issues commonly raised in the PHC Jan Sunwais in first phase

1. Infrastructure- There is a mixed picture as far as the infrastructure of the PHCs is concerned. Some PHCs in Amaravati district have been in a dilapidated condition for many years. A similar situation was also reported from Nandurbar district. One generic observation across all PHCs was poor general cleanliness and inadequate water supply. Another issue which was widely reported was unavailability of generators for provision of electricity, when load shedding at some places was as long as 10 hours every day.

2. Availability of medicines- while some PHCs have a basic functional stock of medicines, in several other PHCs medicines which are indented are not fully supplied. This problem was acute in one block each of Amaravati and Nandurbar. It was also noted that some amount of substitution of medicines by dispensing alternatives is being done. In Amaravati district in one PHC, large quantities of expired medicines were discovered by activists and were thrown out[1].

3. Shortage of staff- Across all PHCs there were reported to be significant number of vacant posts both within the PHC and in the field. This needs to be corrected by appointment of staff at the earliest.

4. Performance of the outreach functionaries- In general it has been observed that ANMs are performing relatively well in and around the Sub-centres where they are stationed, however their performance in the more distant villages or hamlets has been unsatisfactory. In Dhadgaon block of Nandurbar district, performance of ANMs across all the pilot villages was reported as poor. This acquires a special significance considering the fact the state government has put in lot of resources in this district to address the long standing issues of malnutrition and high infant mortality rate.

5. Performance of the Anganwadi Workers- In the first round, it was reported that there are gross irregularities in the way the ICDS department is operating in Nandurbar district. This issue was highlighted in most of the PHC level Jan Sunwais in two blocks of the district[2]. Main issues raised were underreporting of child malnutrition, and the provision of inadequate and nutritionally poor quality food in the Anganwadis.

[1] Around this time several news items were published in newspapers regarding expired medicines in certain Public Health Institutions and also corruption in medicine procurement. Though this probe was initiated by individuals who are not linked with CBM, it also indicates a need to monitor the availability and procurement of medicines more closely.

[2] One of the organisations working in Akkalkuwa block of the Nandurbar District has published a shocking report on malnutrition and infant deaths in the district and also pointed out serious deficiencies in the ICDS department as well as the PDS.

B. District level Jan Sunwais

The district level Jan Sunwais were held at the district headquarters to ensure the presence of the district level health officials. This needs to be specially mentioned keeping in view the fact that in most of the pilot districts, the blocks where the project is implemented were quite remote from the district headquarters. At some places, this has affected participation of community members, however in all districts participation in this event was significant and the number of representatives attending were often in the hundreds.

1. Key issues emerging from various District level Jan Sunwais in first round

In this section some major issues which were raised in the first round district Jan sunwais which were organized in October - November 2008, are briefly highlighted, especially those requiring district level or state level intervention.

Availability of Medicines

In general, in the first round there was widespread unavailability of common and special-needs medicines across the districts that were covered by CBM. Certain drugs in specific places were found to be in major excess, thus contributing toward imbalance in distribution, there were also places where expired drugs are being disbursed due to the excessive stock of specific medicines.

- In Thane district most of the PHCs and rural hospitals were dealing with issues of unavailability of essential drugs. It was also reported that the rural hospitals are running low on antibiotics; at the same time drugs such as Ranitidine were in excess.
- Representatives of the block nodal NGO in Akkalkuwa and Dhadgaon in the district of Nandurbar have shown that most of the PHCs do not have adequate availability of anti snake venom, TT injections, and disposable syringes. There the mechanism of local procurement of medicine was not revealed to community monitoring agencies in spite of repeated requests.
- The district of Pune as well displayed a wide range of unavailability of essential medicines, such as injection Methergin, Paracetamol syrup and Cotrimoxazole syrup were not in sufficient amounts. A PHC in Purandar block reported disbursement of expired drugs.
- This problem of storing expired drugs was also observed and reported in the district of Amaravati.

Incentive based schemes such as the Janani Suraksha Yojana and Matrutva Anudan Yojana

Incentive based maternity related schemes have been designed with the objective that those who qualify and meet the conditions can benefit by receiving monetary or service-

based help after the birth of their child. In this regard, key complaints which emerged in hearings were -

- In the district of Nandurbar in the first phase, there have been reports of delay in reimbursement of funds, partial payments and demands being made on mothers to submit several documents. In the cases of delay in payment for over three months, the DHO reported that there was a delay in receiving money by the district itself. Due to difficulty in doing paperwork and arranging for specific documents, many Adivasi beneficiaries weren't able to claim their money. Also since incentives are only provided at the PHC or the RH, new mothers have a hard time traveling with a newborn within 10 days of the delivery to make their claims.

- Both districts of Amaravati and Thane reported delayed payments or partial payments, however officials from Thane reported that funds weren't disbursed to the RHs and PHCs in time delaying the payments down the chain.

Outreach and Anganwadi functions

Outreach work and other responsibilities are fulfilled by health staff, the appointments of many of these are on a contractual basis. One of the main issues revealed at the District level Jan Sunwais was the large number of vacancies for MOs, specialist doctors, lab technicians and ANMs.

- An interesting appointment in the district of Nandurbar was that of a doctor who was incharge of one PHC and also holding additional charge as an ADHO which resulted in the absence of this MO from the PHC.

- The topic of inadequate compensation for ASHAs and Dais was raised by representatives from Thane district. Giving activity-linked support to ASHAs from village untied- funds was suggested be explored in this case.

- Self help groups from Amaravati district have complained that they do not get subsidized rations from PDS stores for supplying food to Anganwadis, and reimbursement for such expenditures is often delayed. There have also been reports from Melghat in district Amaravati, where some Anganwadis are providing services to up to seventy children at a time with limited human resources.

Infrastructure and Human Power in Public Health Institutions

Lack of cleanliness, poor ambulance services, inadequate water supply, vacant posts, inappropriate locations of PHCs and inappropriate utilization of untied-funds are some of the major issues highlighted at the Jan Sunwais across all districts.

- Compulsion to hire a private vehicle to transport mergencies to the PHC in the absence of an ambulance was a frequent complaint in Nandurbar. However obtaining reimbursement for such expenses was reported to be difficult and mostly unsuccessful.

- Similar stories of individuals not receiving reimbursement for arriving at PHCs by private vehicles, even for transfers from PHC to RH were reported in Thane.
- In Amaravati wherever ambulance service is available it can only be used to go to the rural hospitals, patients have to arrange for separate transportation to sub districts or district hospitals, after getting permission from the civil surgeon.
- In Thane, there was also a report of a MO who sold injections on the roadside, but due to the CBM process he was exposed. The lack of X-ray facilities at a PHC was reported, linked with the lack of a generator or inverter.

Lack of functioning lab facilities, ambulance services and even of specialist doctors was reported from Pune district.

Selected instances of denial of Health care

- Serious complaints were voiced by certain women patients concerning **RH Chandoli** (Tal. Khed). The women accused a surgeon there of having demanded large amounts of money for performing cesarean operation. It was alleged by two women that cesarean operations were denied when they refused to pay the illegal bribe of Rs. 5000 that was demanded.
- Similarly, another woman who had undergone sterilization in **RH Chandoli** one and half years back, became pregnant (a clear case of sterilisation failure) yet when she approached the same RH for D&C (abortion), Rs. 1500 were demanded by the doctor. It was only after the intervention of a local journalist and the threat of media exposure that this demand was withdrawn and the abortion was performed.
- A complaint was voiced by a woman who approached **RH Saswad** (Tal. Purandar) during labour, and was asked to get an ultrasound performed from a private clinic as a precondition for the delivery being done in the RH. This was despite an earlier, normal ultrasound report for the woman being presented when she approached the RH. Ultimately, delivery care was denied to her and she had to undergo delivery in a private hospital.
- It has been observed that in many PHCs the tendency of **directly referring women in labour** without even examining the patient is growing. There were at least three instances where a woman was referred to the rural hospital or the private hospital citing complications. However all these instances the woman had normal deliveries after reaching the referral hospitals. (It was suggested that in every PHC there should be clear guidelines about referrals. In cases where it is found that the referral was unwarranted, an enquiry should be conducted).
- In **Naldurg PHC** in Osmanabad district, people complained that even simple delivery cases are routinely referred to a nearby private hospital. One concrete case was

reported wherein the woman who had come for delivery at 4 PM was asked to go to the private hospital. She was in no position to do so and was delivered by a nurse, who was actually on leave but had come to PHC for some other work. The doctor did not do anything to assist the woman in labour. After the delivery, the mother and baby were left alone in dark in the PHC at night.

Glimpses from the Jan Sunwais-

"These Jan Sunwais led to a significant change in peoples perception about health services, the way they are demanding services, we do not think we would be able to fulfil their expectations"- PHC MO in Osmanabad to the district coordinator.

When we asked Ashwini Dorwat, district coordinator of Osmanabad, to name the single CBM activity which led to maximum impact, her affirmative answer was 'Jan Sunwai'. Jan Sunwai is a potent tool to create social pressure on the authorities and also to make them responsive. As Ashwini puts it, "As a single strategy Jan Sunwai is very effective, it has led to one or the other positive change right from the district level to the PHC level". Upon asking her to specify what types of changes she has seen, she said "Outreach and Anganwadi functions have definitely improved, PHC services have somewhat improved and the district authorities are now at least willing to sit and discuss."

"How can you transfer an efficient doctor like Dr. Miraj Ali? What forced you to take this decision when people are against it? Sir we need an answer"- Group of women from Dhamangaon Gadhi in the Amaravati district level Jan Sunwai, speaking to the DHO.

Amaravati district Jan Sunwai was unusual, because it was the first time a PHC MO came to present her own grievance. Her testimony exemplifies the difficulties faced by well intentioned and sincere officers in the health bureaucracy.

Dr. Miraj Ali had been working as a PHC MO in Dhamangaon Gadhi for the last one and a half years. People have reported that she has been quite instrumental in improving the health services of the PHC, this was by no means a small achievement considering the fact that the same PHC was almost dysfunctional before she was appointed there. She had been staying in the PHC from the day of her appointment and naturally, the number of OPD patients, especially women patients, had increased significantly.

In the Jan Sunwai around 20 men and women, including one Zilla Parishad representative, travelled all the way from their village to Amravati town and strongly protested against her unjustified transfer. However the DHO of Amaravati who was present in the Jan Sunwai was quite dismissive and non-committal. Around 325 people residing in Dhamangaon had signed a petition to reinstate Dr. Ali and the Zilla Parishad member from Dhamangaon has also endorsed this demand. This petition was presented in the Jan Sunwai.

What was striking was the way ordinary women from Dhamangaon supported Dr. Ali. We still remember a frail looking woman who came to the Sunwai at her own expense and warned the DHO not to play with the sentiments of people in Dhamangaon since every house in the village knows about the contribution of Dr. Ali.

"Please do not promise something which you know very well is impossible to provide, we don't want you to promise us guaranteed health services, just ensure that your doctors are present in PHC on the stipulated time and they behave properly with us."- One villager in PHC Jansunwai in Murbad to Taluka Medical Officer.

2. Some key issues raised in the second round of District Jan Sunwais

The second round of district Jan sunwais were organized in all five districts in the period February to April 2010. Some common issues such as large numbers of vacancies, unavailability of medicines, and continued infrastructural deficiencies were reported at these Jan Sunwais.

In Pune district, as far as availability of essential drugs is concerned, a wide and significant discrepant trend was reported between rural hospitals and primary health centers. Some medicines were significantly lacking in PHCs and the same medicines were in excess quantity in certain other PHCs. In Purandar block doctors at the Rural hospital routinely refuse services to pregnant women who are HIV positive or have AIDS. Another important issue raised was the 'directives' by ICDS officials towards spending village untied funds mainly on the Anganwadi programmes, even though the funds are supposed to be spent on various village-specific needs.

In the district of Thane instances of non availability of medicines were widely reported. It was also found that in some of the health facilities, stock of medicine was significantly less than the standard norm e.g. in less than 50% of the instances surveyed, there was sufficient stock in Murbad, Tokawde rural hospital and Dahanu sub district hospital. It was also reported that the quantity of food received by BPL inpatients was quite inadequate and drinking water was not available at the sub district hospital of Shahpur, similar observations were made regarding Jawhar subdistrict Hospital. Due to infrastructural problems one of the more significant problems reported at the sub district hospital in Dahanu was the dysfunctional sonography machine.

In Osmanabad district, in the Rural hospitals of Osmanabad and Tuljapur blocks, surveyed instances of medicine availability revealed that in only 15% of the instances, medicines were available as per standards. Naldurg PHC have closed down their premises due to staff disputes while MOs of Tuljapur block are uncooperative with the block nodal NGO; they refuse to participate in CBM events and are not present at scheduled CBM meetings. An audit of the Rural hospital in Osmanabad also revealed that the hospital was very small, with only 20 beds available for inpatients, thus at the time of inspection it was empty of any patients.

In the Amaravati Jan Sunwai, issues like vacant posts of specialist doctors, nonfunctioning ambulances, irregularity in the outreach services and instances of denial of health care were shared by the participating organisations. In this Jan Sunwai interestingly the Civil Surgeon pointed out that although unavailability of specialist doctors is a problematic issue, monitoring agencies should also squarely question the State government's policy of allowing existing specialist doctors in the Government health services to continue doing private practice. According to him this often results in absence of specialist doctors during official hours of duty, primarily because their priority is private practice.

In the Nandurbar District level Jan Sunwai, survey findings regarding availability of essential drugs from 7 PHCs and 2 sub district hospitals were presented. There seems to be some general improvement in availability of essential drugs as compared to the survey done prior to the first round of Jan Sunwais. In this Jan Sunwai a range of issues regarding ANM, MPW vacant posts was shared. Participants in this event shared their experience regarding inadequate health services and poor quality of food given to the patients in the District Hospital.

It should be noted that around one hundred health related Jan Sunwais have been organized in Maharashtra at various levels so far, since the inception of the CBM process. These events for public accountability have contributed to a number of improvements in all of the CBM districts and blocks, and this process has led to increased dialogue between people and public health providers. Some of these improvements are mentioned at various places in this report including the section on trends of change and improvements in health services.

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VIII.
State Culmination and Review Workshops

The first state culmination and review workshop to share the collated findings from the first phase CBM processes across the state was held in Mumbai on 6th November 2008. The second such workshop was held in Mumbai on 28th April 2010.

This section regarding the State culmination workshops is divided into two subsections-

A. Summary report of the first State culmination and review workshop (Nov.08)
B. Brief report of second State culmination and review workshop (April 10) with summary of key decisions

A. Summary report of the first State culmination and review workshop (Nov. 2008)

This workshop was attended by the Secretary and Commissioner of Family Welfare, Ms. Vandana Krishna and the Director from Union Ministry of Health and Family welfare, Dr. Tarun Seem. Similarly the Director of the NRHM in Maharashtra, Shri Madhukar Choudhary, Joint Director NRHM, Dr. Satish Pawar and various officials from the Directorate of Health Services were also present for this meeting. The workshop was attended by nearly 100 participants including concerned PHC medical officers, Taluka Medical Officers, DHOs and Civil surgeons; all block and district nodal NGOs and state nodal NGO representatives were also present.

Following are the major issues raised in this workshop and brief responses of the officials-

1. **Non-availability of essential medicines and grossly excess supply of certain medicines to PHCs and Rural Hospitals**

Based on CBM data collection from the facilities, it was reported that in PHCs & Rural Hospitals there has been continued non availability of many essential medicines and people are forced to purchase medicines from private medical stores. ON the other hand, paradoxically a few medicines are being supplied in gross excess to PHCs and Rural hospitals without any local demand; these situations need to be urgently investigated and rectified.

Official response- Present officials responded that funds have been disbursed to RKS for procuring essential medicines; the observations about indent not being followed and excess supply of drugs which were not asked for would be verified and monitored. Officials have also shared that 169 medicines are being procured in the kit that would be dispatched shortly. Henceforth arrangements would be made to ensure that all PHCs receive sufficient amounts of the medicines they require.

2. Allocation of untied fund-

It was shared that the Sarpanch dominates decision making related to the utilization of village untied funds.

Official response- ANM has been given complete authority to utilize the unified funds. In the future, she may be designated as a signatory for the cheques drawn on the Health Department. This would partly solve the mentioned problem, however decision on the expenses would be taken by the VHSC.

3. Recruitment of Doctors and specialists-

A number of instances of Medical officers were reported to be not staying in the PHC premises, similarly observations regarding doctors unwilling to serve in underserved areas were also shared. Almost all organisations have reported about large number of vacant posts of the specialist doctors.

Official response- NRHM Director has informed that the pay scale of doctors has been increased and those who are willing to work in the interior parts of the state are receiving an increased salary and if it is in sensitive areas then salary would be even higher. Similarly private doctors who volunteer to visit the unserved PHCs have been given an honorarium of Rs.15,000 per month. As regards to the specialist doctors it was shared that those currently recruited are being requested to expand their work. It was difficult to get specialist doctors particularly pediatricians and gynecologists to work in rural parts. Presently, MBBS doctors would be trained in pediatrics course and would be given responsibility to provide consultation on the same.

4. Recruitment of ANMs, MPWs, Lab Technicians and selection of ASHAs-

A large number of posts of health personnel including ANMs, MPWs, and lab technicians are vacant. Similarly, the selection of ASHAs has not yet been completed in every district.

Official response- Presently there is a need for more than 10,000 ANMs in the state out of which we have only 3,000. The pay scale of ANMs has been increased, ANMs who work in the urban areas would get a basic salary of Rs. 5000 and ANMs who work in the interior parts of the state would get Rs. 7000 PM . Advertisements for recruitment of 1000 lab technicians have recently been published in all parts of the state.

5. Ambulance Services-

It was reported that in many cases, ambulances allotted for the convenience of the people are either not in working condition, or no drivers have been recruited for them. A serious problem was shared that Rural hospitals are levying charges from patients for transportation.

Official response- In order to deal with the shortage, this year a fresh proposal has been placed for new ambulances. Officials have also shared that an ailing, needy person is permitted to avail of a private vehicle in case of emergency. It is mandatory for the Village Health Committee (VHC) to pay such bills from RKS funds. A circular mentioning that the ambulance

services should be available to BPL patients free of cost would be issued in 15 days. This would be to reinforce the earlier orders passed by the Government.

6. Facilitation of Community Based Monitoring of Health Services

Some of the DHOs and MOs have refused to cooperate with NGOs and have been a hindrance in the implementation process of CBM.

Official response- DHOs orientation would be conducted to sensitize them on the issue. Meetings would be conducted with nurses for developing a people-sensitive approach amongst the functionaries.

7. Other issues-

It was agreed by the officials that a Grievance Redressal Cell would be developed which will maintain a complaint book, which will register all the complaints. A phone number, preferably a toll-free number, would be made public on the basis of a help-line.

B. Brief report of second State Culmination workshop (Apr. 2010) and summary of key decisions

The following were the main issues raised during the workshop.

1. Display of list of guaranteed health services in RHs and PHCs, as mentioned in the NRHM guidelines.

Officials have agreed that the list of guaranteed health services, as mentioned in NRHM should be displayed in the RH and PHC. It was suggested that information regarding the guaranteed health services should be widely disseminated by using media like radio, television and public places like bus stand etc.

State level officials responded that instructions have been issued to the Civil hospitals and RHs to display lists in the out patient department of the hospital, regarding available medicine stock, services, and availability of diagnostic tests. This list will ensure that these orders are indeed followed and the health facilities are periodically reviewed. Further following the guidelines mentioned in the NRHM manual, lists of Guaranteed health services will be prepared as per the Indian Public Health Standards (IPHS). After the approval of this list from the State Government, the list would be sent to RHs and PHCs presently covered under the CBM process with instructions regarding display of this list.

2. Rational allocation of villages to PHCs esp. in areas covered by CBM process.

Process of revised allocation of villages to Sub Centers and PHCs has begun across Maharashtra, as per directives received from state level. Certain officials from the Directorate of Health services are involved in this process. Regarding the revised allocation of villages to PHCs, NGO/CBOs who are working on CBM in 5 districts of Maharashtra, will provide their written suggestions to the DHO and State level officials. These suggestions would also be considered while planning for revised allocation of villages to the Sub Centers or PHCs.

In areas where the re-allocation process has already been initiated, draft of the relocation plan would be posted on the website of the Health Department prior to presenting it to the State Government.

3. Transparency while awarding contracts for repair and maintenance of the PHCs

It was noticed in Nandurbar district that due to substandard construction of the PHC buildings there is a problem of water seepage in Khuntmodi, Chulwad PHCs in Dhadgaon taluka and Sulwada, Wagharde PHCs in Shahada Taluka. With respect to this poor quality of construction, it was expected that some form of enquiry or punitive action would have been initiated against the contractor. Despite of repeatedly pointing out this problem, ironically the contractor who has been involved in constructing these PHCs was awarded the next contract by the health department. It was suggested that the tenders from such contractors should be rejected and a form of punitive action should be initiated. Furthermore the name of the contractor must be blacklisted from any further tender process.

It was also decided at the workshop, that in order to bring about transparency in the contracting process, the MO should display contract process related papers and documents in the PHC. Also these documents should be made accessible to the people, whenever requested.

4. Training period of MPWs presently coincides with rainy season when prevalence of water borne diseases is higher, leading to gap in services.

Presently, training of MPWs is scheduled during the monsoon season, when occurrence of water borne diseases is higher. Hence it was suggested that trainings should be held before or after the monsoon rains but not during this peak illness season. It was also pointed out that other staff like ANMs, lab technicians and doctors complete relevant training before their posting. However, MPWs are provided with training after they are posted. The timing of training for MPWs reduces the effectiveness of these MPW, and only appears to have filled the position while the functionary remains non-available to people.

The officers present justified the process by disclosing the following: up till 1995, MPWs were trained before posting. However, during an epidemic of malaria in the 1980s, the existing number of MPWs were only half of what was required. At that time 3000 MPWs were recruited urgently and these were trained after their posting. This system has continued till date. All health officials agreed that this system needed to be changed. It was agreed that the trainings for MPWs will be done before the monsoon season begins so they would be well trained in a time of need; and orders of such scheduling would be passed on to the MOs.

5. Physical capacity and fitness of health workers in difficult geographical areas

It was pointed out that in certain hilly areas where hamlets are located at long distances and general terrain is treacherous, physical capacity and fitness of health workers should be kept in mind before posting. Otherwise this leads to defaulting of visits by health functionaries.

6. Clarity about criteria for referring patients from health centers

Citing some examples of unnecessary referrals, it was pointed out there should be clarity among the health functionaries regarding how, when and in which situation a patient should be referred to higher referral centers. Officers present promised to hold meetings and discussions with related staff to resolve the issue. A circular in this regard has been prepared and it will be provided to the NGOs/CBOs involved in CBM.

7. Irregular reimbursements to Self-help groups which are supplying nutritious diet for Anganwadis

There were some instances when cheques issued to the self- help groups bounced. Moreover, self help groups often do not receive timely or sufficient payment. This situation has led to a situation where some groups are not in a position to properly supply food items to Anganwadis.

It was decided that a representative of ICDS department would be invited for the next State mentoring committee meeting. This issue comes under ICDS department, thus they should be approached for implementing a solution.

8. Citizen's health charter has not been displayed; lack of clarity regarding the complaint redressal process

Citizen's health charter has not been displayed in many PHCs and RHs. There is no clarity regarding how to lodge complaints and method of addressing such complaints. It was pointed out that presently the health functionary against whom the complaint has to be lodged may be the same person who performs the task of enquiry. Further, the complainant may have to spend money from their own pocket, lose wages and travel long distances for making the complaint and related follow up. Present officers suggested that in such cases, the complainant should approach an officer who is senior compared to the person against whom complaint is to be lodged. The enquiry should be conducted at the institution where the alleged violation has taken place rather than at the distant district headquarter etc. In case there is lack of resolution at the district level, unresolved complaints would be taken up at the State level. Information boards regarding complaint redressal mechanisms for health services will be displayed in all the health centers.

Present officials also stated that:

1. A grievance redressal cell has been started at the state level. A related notification was posted in the newspapers.
2. Shortly, such redressal cells would be formed in all the regions of Maharashtra.

Suggestions given:

1. Representatives from civil society, from NGOs/CBOs involved in CBM should also be included in all the regional redressal cells.
2. The mechanism for submitting complaints and seeking redressal must be kept as simple as possible, which would facilitate articulation of complaints.

9. Inadequate availability and uneven distribution of medicines

The latest round CBM data on uneven availability of medicines in various PHCs was presented. Based on this, certain suggestions were made regarding procurement and distribution of essential medicines:

1. The Tamil Nadu model of transparent procurement and effective distribution should be adapted / modified and implemented in Maharashtra. There should be complete transparency in medicine purchase and availability.
2. To overcome problems of stock disparities, data about estimated requirement of medicine stock should be regularly obtained from all the districts. Required stock should be calculated, using the average of 3 years requirement, current stock and 15% additional stock should be indented. Availability of medicine stock should be monitored at the state level.
3. Medicines should be purchased only from manufacturers and not from retailers. Instead of brand name, generic names of medicines should be used as per WHOs recommendation.
4. NGO / CBO representatives responsible for CBM should be allowed to participate in the meetings where purchase / procurement related decisions are taken.
5. Information regarding medicine purchase process, distribution and availability should be displayed on website.
6. Wherever it is noticed that excessive stock has expired due to negligence of health officials, punitive action should be taken.
7. Mobile van should be used to distribute medicines in the case of emergency.
8. In emergency situations when certain medicines are not available, these could be bought from RKS funds or NRHM untied funds.

The present officials mentioned that:

1. In the previous year, the state government had asked for supply of certain essential medicines from the central government. The Central government advised the state government to purchase medicines on their own from the allotted central government Funds and accordingly medicines were purchased by the state. Later, the central government also supplied the same medicines, which resulted in excessive stock of certain medicines in the state.
2. Revised guidelines are being provided for commonly used medicines. Stock which is in excess but within expiry period can be further used, which would prevent wastage of stock.
3. Some medicines are dispensed to patients on very frequent basis, hence stock of such medicines gets used up and is finished earlier than other medicines.

In addition the present officials gave clarifications regarding the new state level policy for medicine procurement wherein medicines will be purchased by tendering which would be done only by the State Govt. Relevant information regarding medicine purchase process, distribution and availability would be displayed on the website.

10. Need for adequate facilities and transparency in recruitment regarding health staff

The following issues were raised regarding Health staff:

1. State government should recruit officers, specialist doctors and other staff in the PHCs and RHs on permanent basis rather than the present contractual basis. The system of contractual employment should be phased out and permanent employment should be provided at various levels. This would enhance staff continuation and morale.
2. All necessary facilities related to work and residence including good quality quarters, electricity, transport, telephone etc should be provided to the doctors and other staff.
3. There should be transparency in the process of appointment, posting or transfer of all staff. Information regarding this should be posted on website of Maharashtra Govt.

11. Addressing corruption issues in the health department from village to the state level.

To ensure transparency in medicine procurement, related information should be made available on the website. All information such as, selection, transfer and recruitment process of doctors and other staff use of funds must be open and available for public access.

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IX.
Media Coverage

One of the key strategies of CBM has been to involve the media in creating public opinion about the state of the public health system and also to positively influence decision makers. It was observed that media coverage has induced officials to respond to pressing issues that were publicised. There has been a general experience of the implementing organisations that whenever media reports about the existing deficiencies in the public health services were published in the local newspapers, DHOs and other functionaries have taken it seriously and have tried to address the issues at their level.

Some of the strategies adopted for effective media coverage include-

1. **Appointing a state media consultant**- a working journalist with experience of facilitating media coverage of developmental and health issues has beenassociated as a consultant with the entire process of CBM. This was an innovation which proved quite effective in involving senior media persons from multiple major newspapers, and ensured continuous following up of involvement of the media at both state and district level, including the electronic media.

2. **Appointing and orienting media fellows**- At the state level two media fellows were designated to cover the CBM activities. These journalists belonged to two major Marathi dailies with multiple editions in various parts of the state to ensure adequate regional as well as state level coverage. Similarly at the block level one media person was assigned in each block to cover and report on the CBM related block activities.

3. **State media workshop**- In this one-day workshop, media participants were familiarized with the process of CBM. This workshop was planned when the first round data from 128 villages was already available from the state nodal NGO. Preliminary analysis of this data was presented in the workshop. Notably the NRHM State Director Shri Madhukar Chowdhary was also present for this workshop. This helped the media persons present in the workshop to get the official perspective on the reported deficiencies from the 128 villages.. The workshop also stressed that along with highlighting specific instances of denial of health care, more emphasis should be given on the processes of monitoring viz. processes of community mobilization and participation, data gathering and filling up of report cards.

Till date a total of over 200 news items have been published in national, state and regional level news papers, concerning community based monitoring in Maharashtra. Similarly, events like Jan Sunwais and the state review workshop were significantly reported in the electronic media.

Observations about media coverage

- Although it was repeatedly emphasized that processes are more important than outcomes, media reports have mainly been about the events e.g. specific instances of deficiencies in the public health system and instances of denial of health care were highlighted. However after repeated interactions with the media fellows, subsequent reports were somewhat more attentive to community level processes and innovations.
- After a few initial one-sided reports, media fellows were specifically instructed to always take the version not only of monitoring NGOs, but also from officials at the relevant level. It was strongly suggested that they should always present both sides of the story rather than giving sensational news headlines.
- In one district, the DHO was upset about the negative media reports and strongly contested findings that were mentioned in it. Though it has not resulted in a backlash, implementing agencies were forced to rethink about the strategy of approaching media. Clearly, district level media advocacy is a powerful tool but one-sided or sensational coverage may lead to the alienation of officials and disruption of dialogue which must be definitely avoided.
- In one of the pilot districts where cooperation of the district level officials in the process of monitoring was very poor, media coverage about the existing deficiencies in the public health system led to immediate response from the officials. It seems that as a strategy, media advocacy led to some positive outcomes even in a previously non-cooperative environment.
- Right from the beginning of the community monitoring process, there is a tension between the way media coverage has been perceived by the implementing civil society organisations and the health officials. Implementing organisations have felt that media intervention is indeed a very effective strategy for highlighting and facilitating solution of long pending issues. There are instances where after media reports, otherwise non cooperative health officials invited representatives of implementing organisations to discuss pending issues which were afflicting local health services. Some of the implementing organisations vouch for effectivity of media interventions by sharing their observation that when all other strategies of monitoring were not yielding desired results, the strategy of involvement of media has worked in reality. However some Government officials have expressed misgivings about the process of involvement

of media, even though media involvement in the process of community based monitoring has been explicitly stated in the CBM national framework itself.

- It should also be kept in mind that media reporting has also publicized improvements that have taken place due to CBM. However if media is performing its duty of highlighting any problems in the health system, on behalf of officials it needs to be looked at objectively and the focus should be on verifying the facts. All media coverage which is based on facts needs to be addressed seriously in the spirit of correcting deficiencies. As an implementing organisation, the State nodal NGO has always briefed media people to ensure objective reporting, to take the version of officials and to avoid sensationalism. During such interactions it needs to be kept in mind that the media has its own autonomy to interpret facts and to publish reports.

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X.

Trends of Change and Improvements in Health Services in CBM Areas

In this chapter, based on analysis of three rounds of village and PHC level report cards over the period of about one and half year, the comparison of ratings over this period of time have been summarised. This gives us an idea of the trends of change, including improvements in health services in this period of CBM implementation.

I. Quantitatively documented improvements in health services in CBM areas New forms of Community mobilization on health

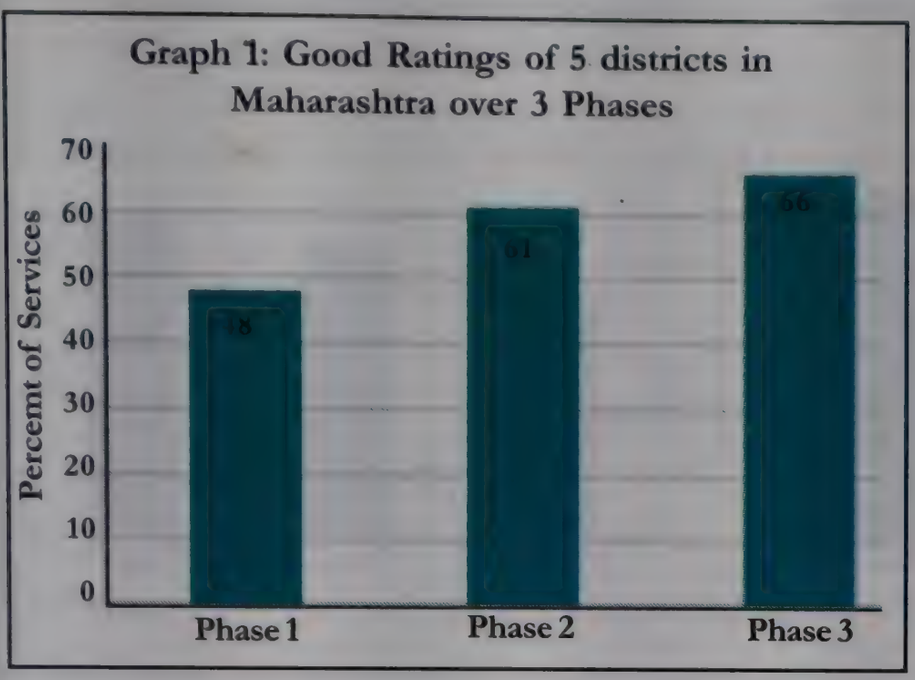
Significant improvements in certain services have taken place in the mentioned period, which are due to a combination of NRHM 'supply side' inputs and 'demand side' push by CBM. *Combined with NRHM related increased funds, administrative drive and reorganization 'from above, the* **CBM process under NRHM has provided a matching yet critical 'push from below'** *to help ensure that desired changes are actually implemented.* Availability of finances, supportive directions and untied funds give the basic inputs for improvement to the local health facilities, and do enable certain changes. But when combined with this, people collectively monitor the activities of ANMs and MPWs, periodically visit the PHCs and audit the availability of medicines and services, document the regularity of services and behavior of providers, point out irregular practices, and repeatedly raise these issues with officials at various levels, then the enabling climate created by NRHM is more likely to result in real improvements at the ground level.

At the same time, not all aspects of the health system are amenable to improvement by Community based monitoring, and larger constraints like non-availability of skilled staff or medicines may limit the overall possibility of improvements. Such largely systemic problems, which highlight the need to ensure positive changes at policy levels, are described in the last section of this chapter.

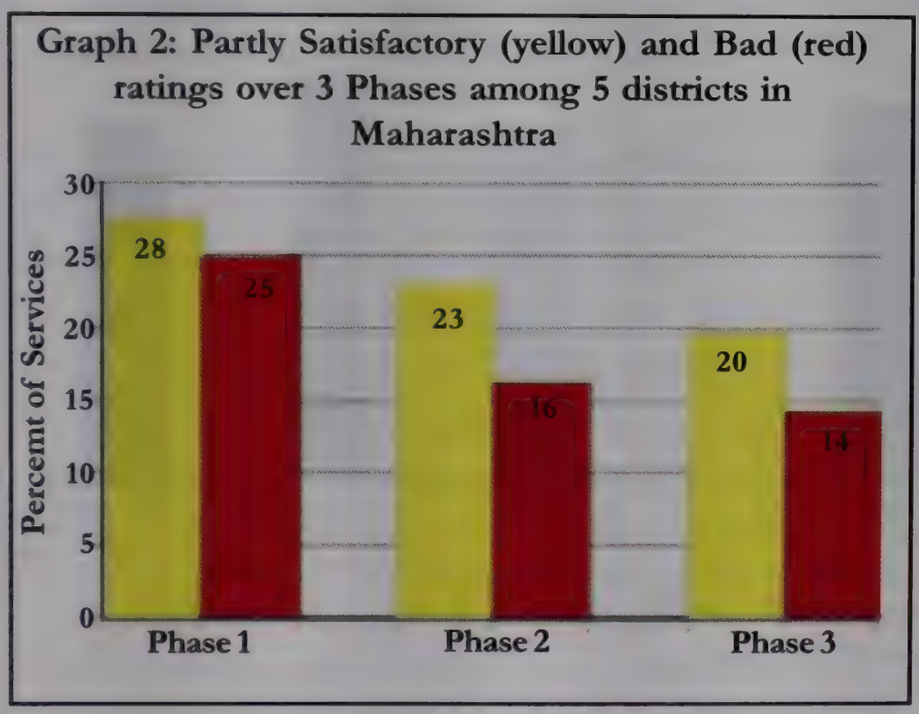
Below we have briefly analyzed the data gathered over a period of one and half year in 3 phases of Community based monitoring.

1. Improvements in Village level health services

Regarding Village level report cards, nine key health services were rated by Village Health committee members as either 'Good', 'Partly satisfactory' or 'Bad'. This information was collected from the approximately 220 villages where report cards were prepared across all three rounds. Graph 1 shows the trend of good ratings for these services across 5 districts in

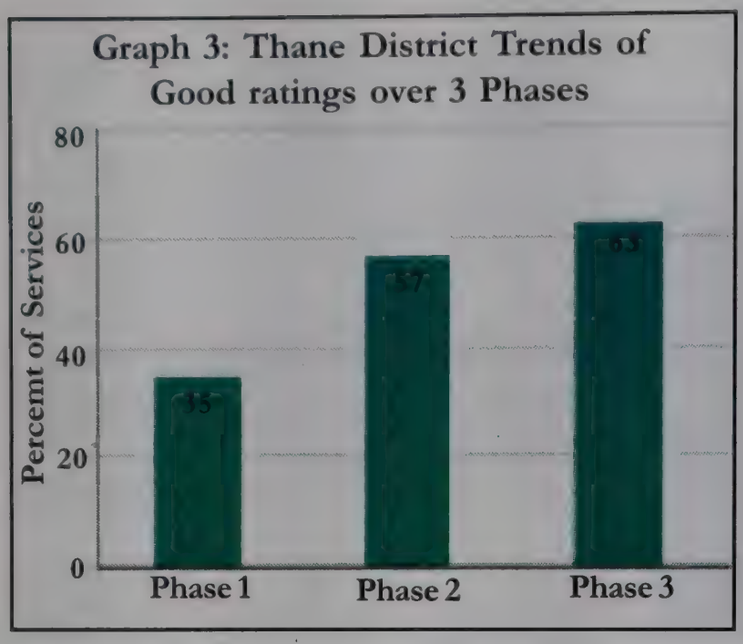


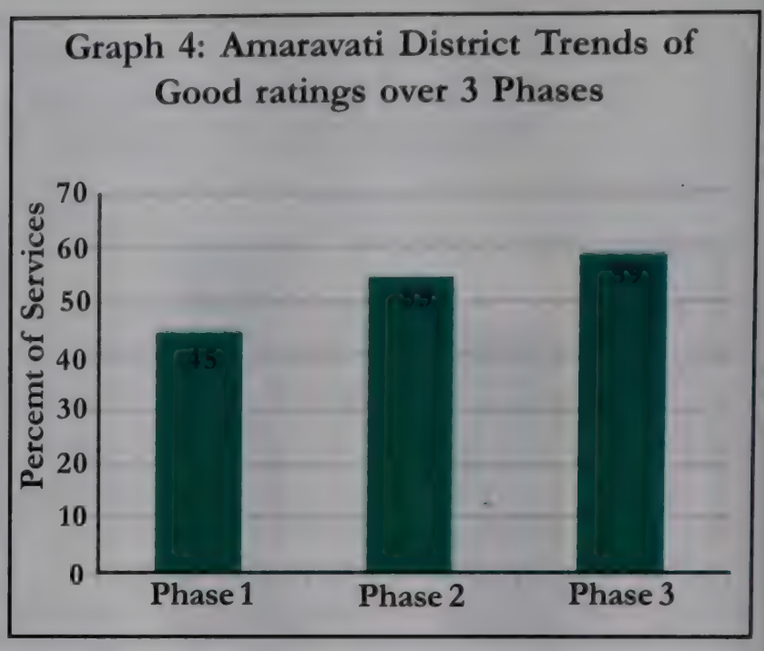
Maharashtra over the 3 phases of CBM. 48% of the services were given 'Good' ratings in Phase 1, this increased to 61% in Phase 2 and further to 66% in Phase 3. Thus **there has been a consistent overall improvement in Village health services in the CBM covered villages.**

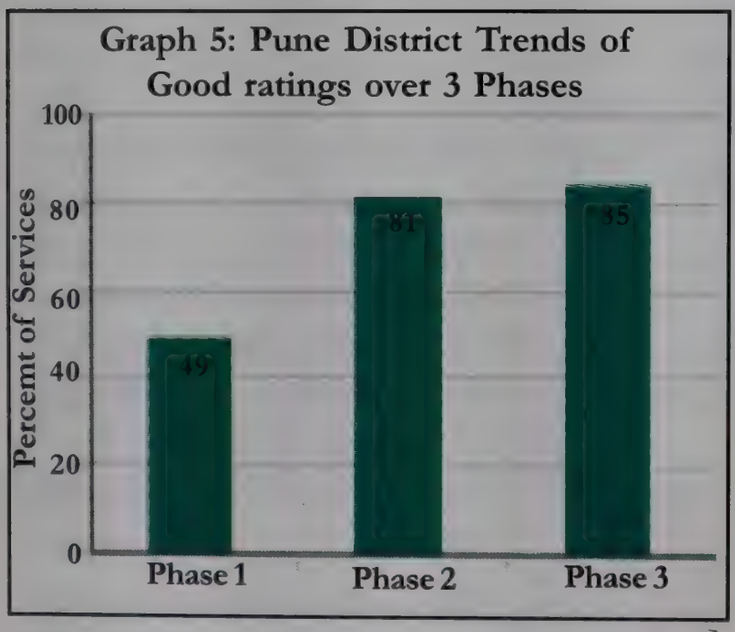


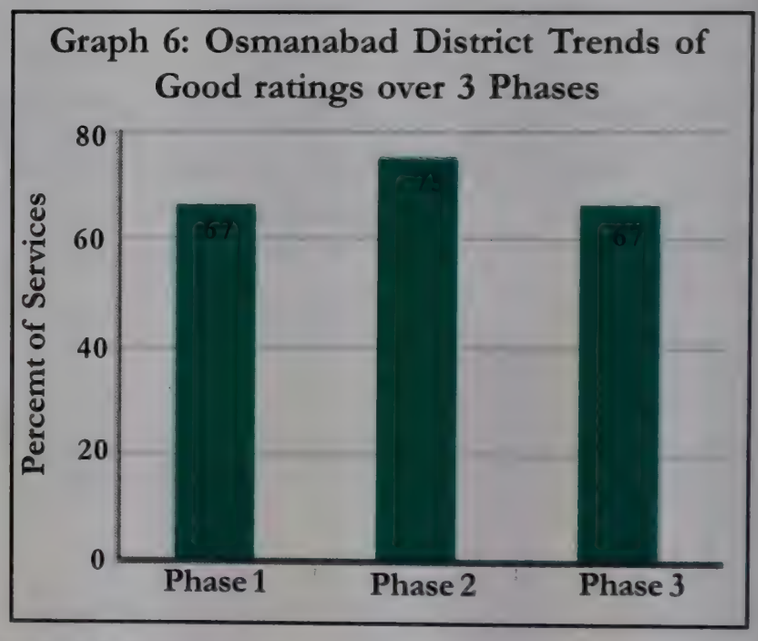
Similarly Graph no. 2 shows the concurrent reduction in 'Partly satisfactory' (yellow) and 'Bad' (red) ratings of services in these 5 districts over the 3 phases of CBM. Services rated as 'Bad' have reduced from 25% in the first phase to 14% in the third phase.

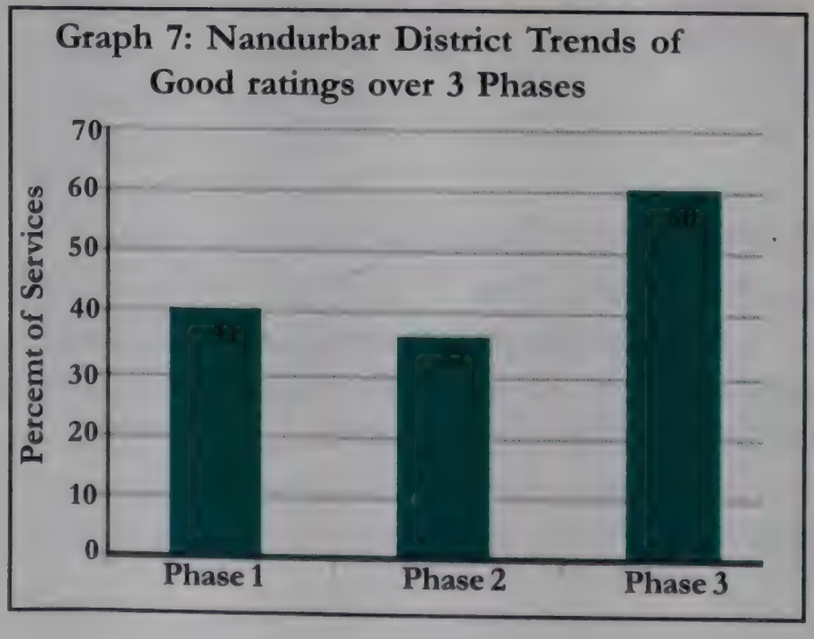
We need to further see how these changes have varied from district to district. An aggregate 'Good' evaluation trend for each district over the 3 phases of CBM is shown through the following graphs (Graph nos. 3 to 7). In three districts (Amaravati, Pune and Thane) we may observe definite improvement between Phase 1 and Phase 2, and these improvements have leveled off between Phase 2 and Phase 3. In Nandurbar, ratings remained poor between Phase 1 and Phase 2, but have improved significantly by Phase 3. The ratings for Osmanabad improved slightly between phases 1 and 2, but returned to initial levels by phase 3.


Graph 3: Thane District Trends of Good ratings over 3 Phases
Percemt of Services
80
60
40
20
0
35
57
63
Phase 1
Phase 2
Phase 3

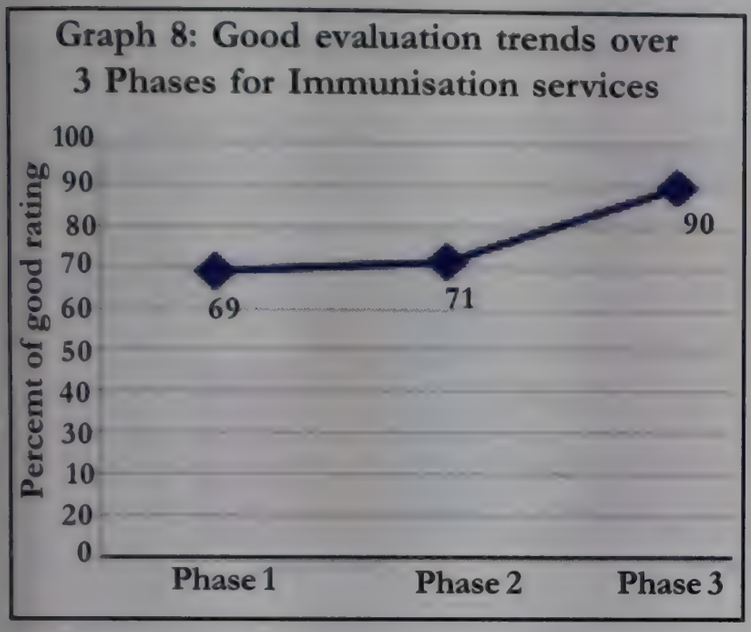

Graph 4: Amaravati District Trends of Good ratings over 3 Phases
Percemt of Services
70
60
50
40
30
20
10
0
45
55
59
Phase 1
Phase 2
Phase 3

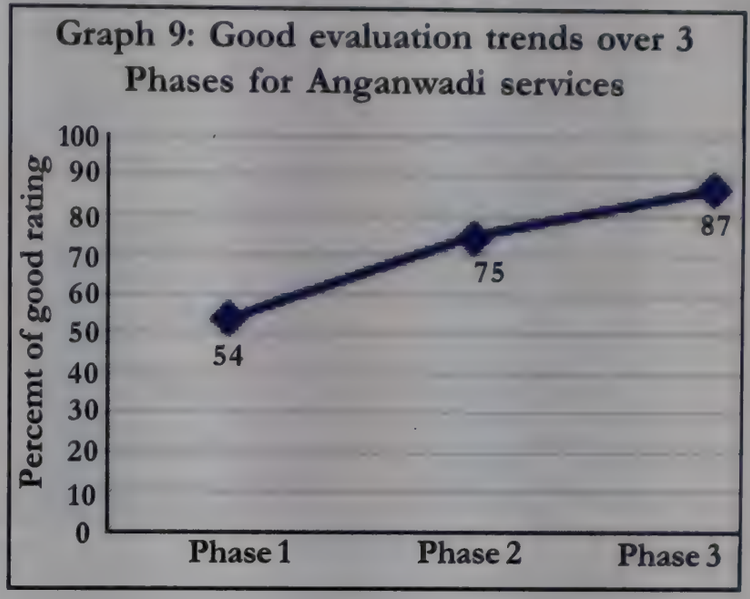

Graph 5: Pune District Trends of Good ratings over 3 Phases
Percemt of Services
100
80
60
40
20
0
49
81
85
Phase 1
Phase 2
Phase 3


Graph 6: Osmanabad District Trends of Good ratings over 3 Phases
Percemt of Services
80
60
40
20
0
67
75
67
Phase 1
Phase 2
Phase 3


Graph 7: Nandurbar District Trends of Good ratings over 3 Phases
Percemt of Services
70
60
50
40
30
20
10
0
40
35
59
Phase 1
Phase 2
Phase 3

Certain health services have shown high and consistently improving 'Good' ratings across the five CBM districts over the 3 phases. At the end of Phase 3, 90% of districts received a rating of 'Good' for immunization services and 87% of districts received a rating of 'Good' for Anganwadi services. The following graphs display trends for these services.

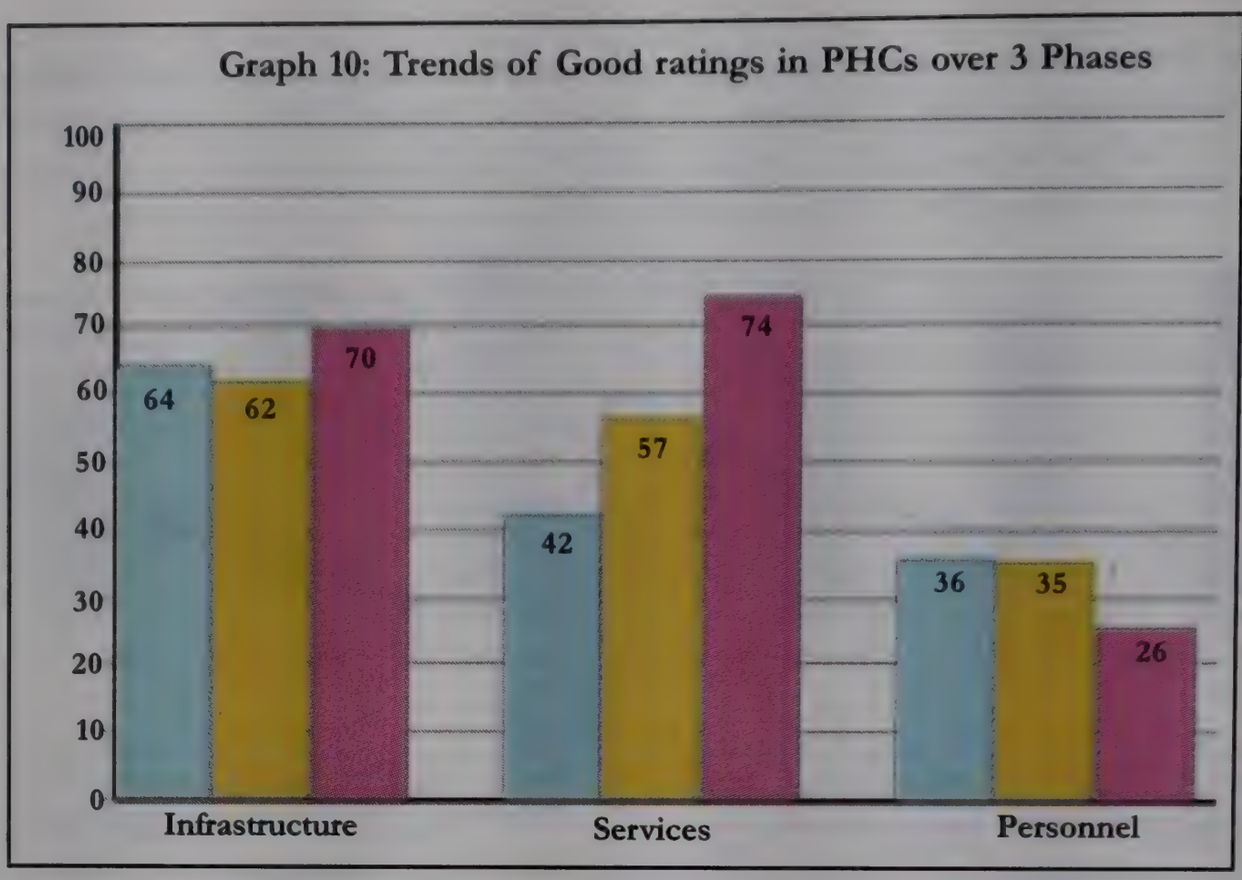




2. Changes in health services by Primary Health Centres (PHCs)

The data collected from PHCs for CBM process can be divided into four broad categories: infrastructure, services, personnel and medicines. The following graph displays the aggregate PHC trends of 'Good' ratings across the 5 CBM districts in Maharashtra over 3 phases (availability of medicines is dealt with in a separate chapter)

Parameters such as availability of electricity, water, cleanliness of toilets and the access to lab tests were evaluated under 'Infrastructure'. Graph no. 10 depicts that 'Good' ratings went up from 64% to 70% between phases 1 and 3, though a slight dip in 'Good' ratings was seen during phase 2. 'Services' refer to 24 hour delivery care, indoor patient services, lab service availability and ambulance for referrals. A steady increase in the 'Good' ratings for 'services' was observed. Only 42% of the ratings were 'Good' in phase 1, they increased to 57% and were calculated to be 74% at the end of phase 3. Lastly the category of Personnel included filled MO positions, present MPWs, present ANMs, lab technicians, ambulance drivers and the condition of provided MO residence. Similar to all other evaluated parameters, the report cards from all the districts were put together to arrive at the aggregates. Although the percent of 'Good' ratings for Personnel stayed the same from phase 1 to phase 2, they have decreased to 26% at the end of phase 3. This aspect is discussed further in the last section.

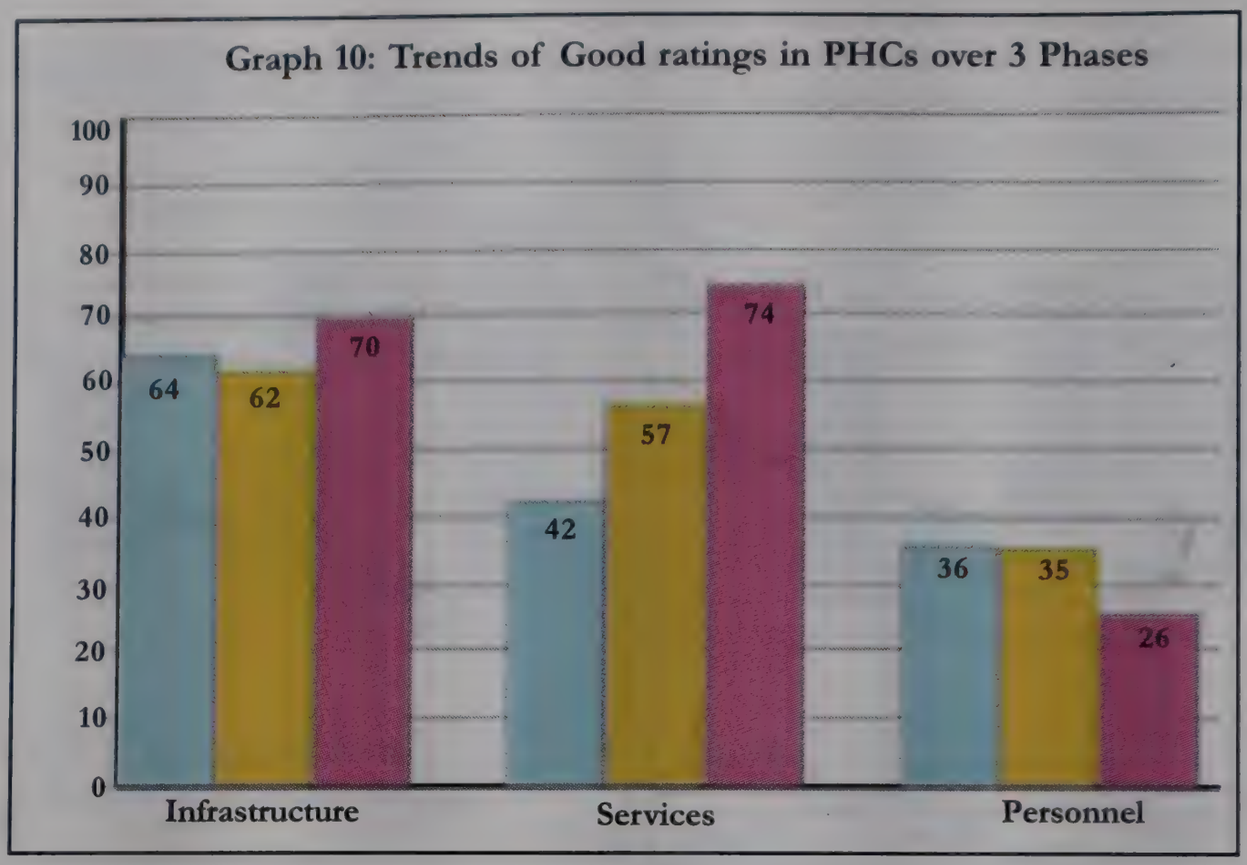


II. Qualitative improvements linked with CBM

As mentioned above, regular discussions and dialogue between health service providers and villagers, civil society representatives have resulted in a range of improvements and changes in health services. **The qualitative improvements listed below concern specific issues which were raised through the CBM process;** of course most of these improvements were actually made possible because of the larger framework and funds available under NRHM. In that sense CBM has not been responsible alone, but has definitely acted as a critical 'push' for NRHM to better achieve its potential at the local level.

1. Thane District - improvements in CBM areas:

- Practice of prescribing medicine from private shops has totally stopped, as some of the required medicines which are not available, are now purchased from the RKS funds.
- Medical officers now do not charge for giving injections to the patients. Private practice of certain medical officers has now stopped.
- Utilization of untied funds for purchasing furniture for Anganwadis has stopped in Murbad block, and funds are used for other more relevant health related activities.
- Based on more accurate recording, there is now no discrepancy between Anganwadi records and independently taken weights, regarding weight of malnourished children.



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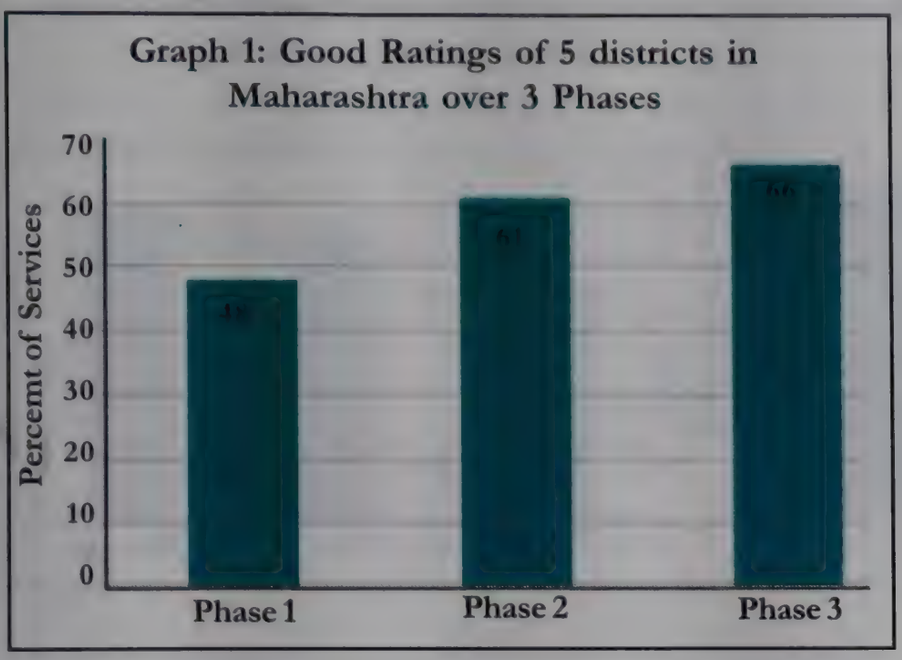

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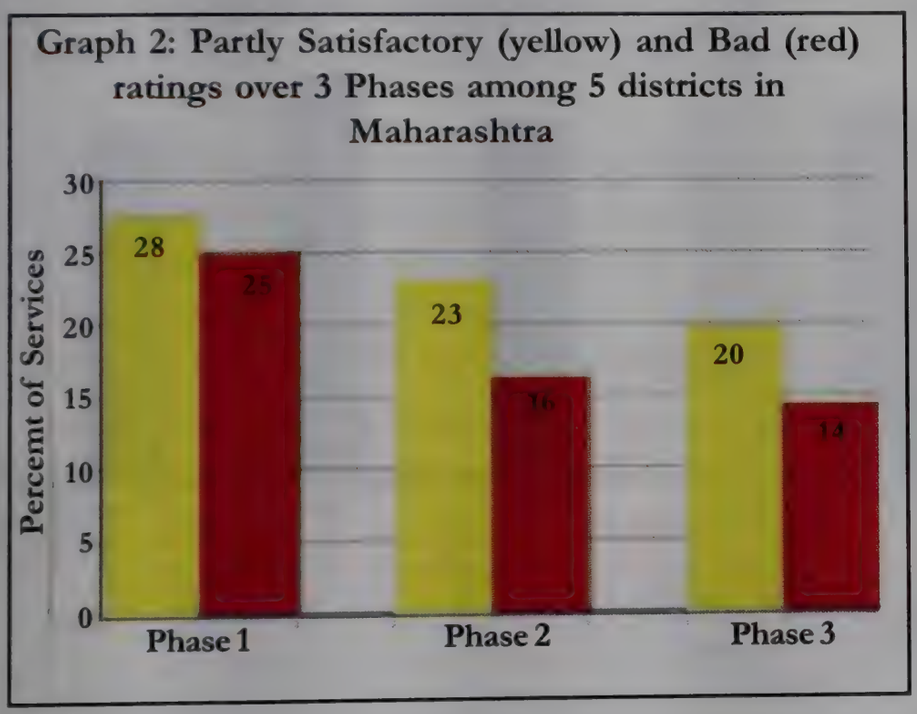

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- In Nandgaon PHC of Jawhar block, a new generator has been installed, earlier there was no electricity supply in the PHC. This issue was raised by the PHC monitoring and Planning Committee in their meetings and was then resolved.
- In Jamsar PHC of Jawhar block, the number of people availing OPD services from PHC has significantly increased based on greater awareness and improvement in services.
- The laboratory in Jamsar PHC was not in function, now it is functioning twice in a week.

2. Pune District- improvements in CBM areas:

- In Parinche village of Purandar block, the Sub centre has now started functioning regularly; earlier it was not functioning properly. This was raised through the CBM process.
- At Malshiras PHC of Purandar block, the previous practice of prescribing medicines from private shops has been totally stopped and all medicines are given from the PHC.
- The number of people availing services from certain PHCs now is approximately twice the number of people before CBM started, in selected three blocks of Pune (i.e. OPD attendance has significantly increased).
- The health charter has now been displayed in every selected PHC of Pune District. Information related to ambulance has been displayed in PHCs.
- As a significant innovation, adolescent representatives (12-17 yrs. age) have been included in the VHSCs in five villages in Bhor taluka and three villages in Velhe taluka, enabling issues of children and adolescents to be raised and addressed in the meetings.

3. Nandurbar District - improvements in CBM areas:

- Bijari sub centre of Dhadgaon block has now started functioning regularly, earlier it was not functioning.
- In Kusumwada PHC of Shahada block, a board has been displayed regarding availability of medicines in PHC.
- In Ohwa PHC of Akkalkuwa block, considering as a special case land has been sanctioned and a new PHC building is now under construction.
- The earlier practice of prescribing medicines from private shops has totally stopped. There is documented improvement in supply of essential medicines in PHCs. This was the result of State level CBM discussion on shortage of medicines in Nandurbar District.

- Implementation of Janani Suraksha Yojana (JSY) has been improved in existing villages and beneficiaries are getting benefits more regularly.
- OPD attendance at PHCs has increased in the selected CBM blocks of Nandurbar District. Frequency of visits of ANM and MPWs in villages has led to improved village health services in some villages; there is definite improvement in immunisation coverage in these villages.

4. **Amaravati District - improvements in CBM areas:**

- The sub centre under Bihali PHC was not functioning for almost two months. This issue was raised in a Public hearing and now it is functioning.
- Earlier there was no ambulance for Dhamangaon Gadi PHC of Achalpur block, now after the issue was raised an ambulance has been made available there.
- Earlier ANMs were not staying at the Sub-centre, now there are resident ANMs in Gaurkheda, Kumbhi and Malhar sub-centers of Achalpur block.
- One mobile unit has been started at Nimdari sub-centre based on demand from the community. In Chourkund village under Harisal PHC, a mobile medical unit has been approved.
- The number of institutional deliveries has increased in Achalpur block. Preliminary data shows a significant increase in the number of institutional deliveries per month.
- Sindhi sub-centre now has a residential medical officer as this centre covers a population of around 7000.
- JSY beneficiaries are now being paid the rightful amount of Rs. 700/- rather than the Rs. 500/- they were being paid before. This issue was raised in the CBM process.
- The earlier practice of prescribing medicine from private shops has totally stopped in CBM areas. PHC staff attitude toward patients has significantly improved in Dhulghat railway PHC of Dharni block.

5. **Osmanabad District - improvements in CBM areas:**

- The number of patients availing services from the PHC is now roughly twice compared to the number of patients before CBM was launched, in Moha PHC of Kalam block and Jagji PHC in Osmanabad block (i.e. OPD attendance has increased). IPD and OPD of Rural Hospital of Kalam block has significantly increased.
- Indian Public Health Charter has been displayed in every CBM covered PHC of Kalam and Osmanabad block. PHC monitoring and planning committee members had raised this issue in their meetings.
- In Shiradhon PHC of Kalam block, on the recommendation of the PHC monitoring committee, a suggestion box for patients has been placed.

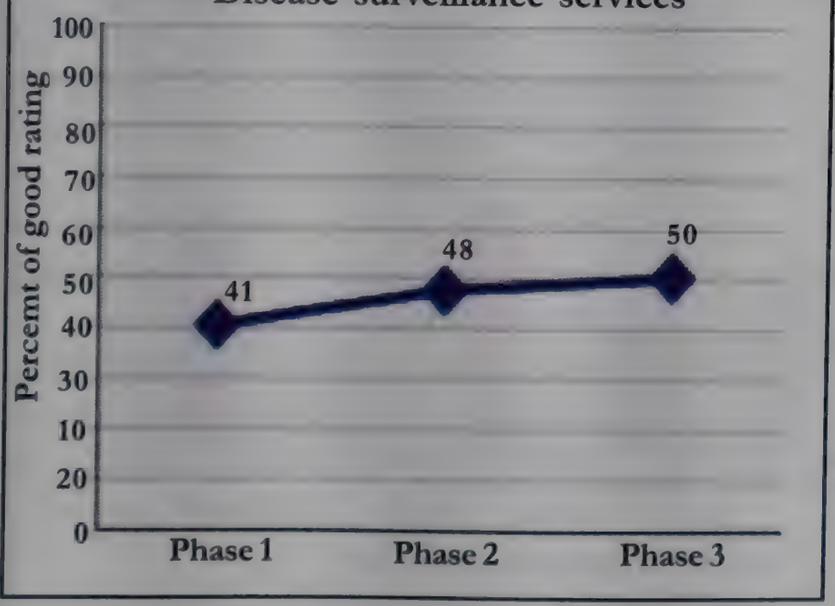
- Names of PHC monitoring and planning committee members have been displayed in selected PHCs of Kalam block and one PHC of Osmanabad block
- Interaction between health care providers and community has improved in Massa. Villagers have taken initiative for giving protection to the ANM, as her quarter is on the periphery of the village.
- Earlier practice of prescribing medicine from private shops has stopped, as some required medicines are purchased from the RKS funds.
- Frequency of visits of ANM and MPWs to villages has increased in most villages. Attitude and behaviour of PHC staff toward patients has improved in all three selected blocks.

III. Stagnation or inadequate improvement of certain health services

Over the period of two and a half years of implementation of CBM activities, many aspects of Health services and facilities have improved such as better availability of immunization services, Anganwadi services and Janani Suraksha Yojana benefits. These are indeed encouraging signs where community empowerment has induced improved performance. However in some areas stagnation and even slight downward trends of ratings of services have been witnessed. Although these are not dominant trends, the following are worth mentioning by way of example.

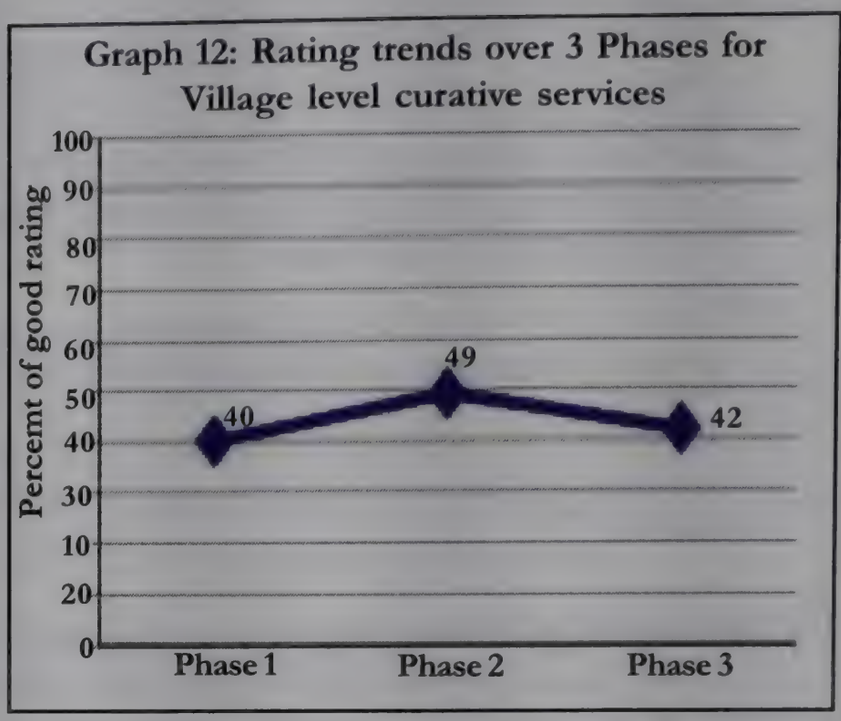
Looking at Village level services, the following three graphs display the trends of certain services (Disease surveillance services, Village level curative services, Use of untied funds) combined for all five districts, whose 'Good' rating status has remained below 50% even by Phase 3. These village level services demand serious attention and need to be improved in all the five CBM districts.

Graph 11: Rating trends over 3 Phases for Disease surveillance services

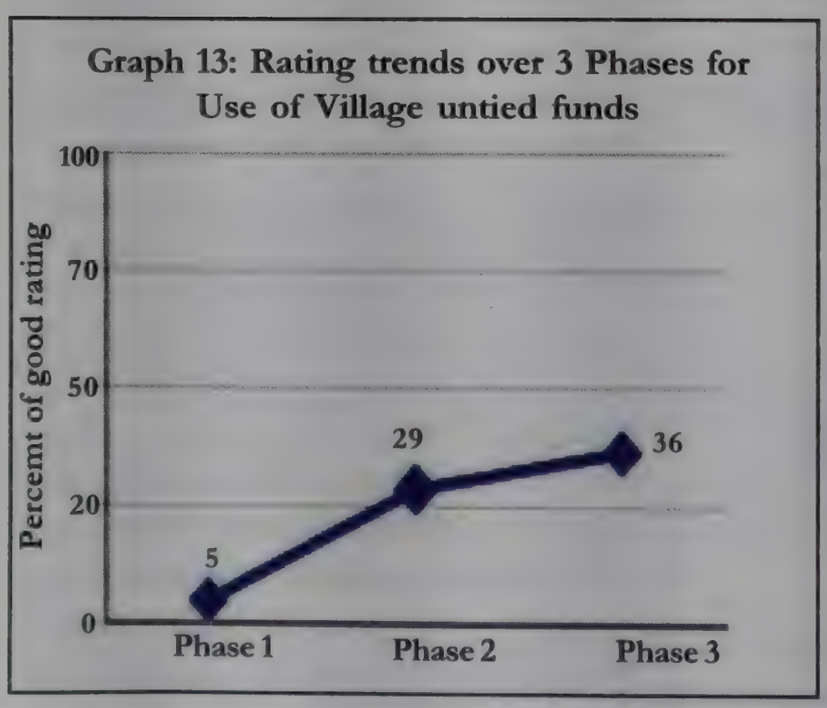


Related to each of these activities, there are some systemic constraints or entrenched patterns of work that may have prevented major improvements. In case of use of untied funds, local ICDS officials are known to often direct the Anganwadi worker to spend the funds according to their own priorities, rather than encouraging and respecting the village health committee's decisions, Disease surveillance is to be carried out by MPWs, however the high vacancy rate of this cadre may have contributed

to inadequate improvements on this front. Provision of first contact care for common ailments is supposed to be done by ANMs during their village visits, however this is regarded as a low priority and ANMs often do not receive the required medicine on a regular basis. Such systemic issues need to be addressed to ensure expected improvements in these services in the future.



Further, related to the data collected from PHCs over the 3 rounds of CBM, there were some aspects whose ratings have seen a slight downward trend in certain districts. As briefly indicated in graph-10, the category of 'Personnel', which includes filled MO positions at PHC, active MPWs and ANMs, lab technicians and ambulance drivers, and the condition of MO residences is worthy of attention. Over the duration of two and a half years, the number of vacant driver positions has increased in the districts of Nandurbar and Amaravati. Number of PHCs with a residing MO has dropped in some districts. Furthermore, although a residence is provided for the MOs on the premises, it seems that over the period of monitoring, lesser number of doctors prefer to stay in PHC accommodation in some areas. Though this needs to be probed further, it seems this situation is partly linked with the poor quality of residences provided. According to the PHC related CBM data, the availability of electricity went down over the three phases in PHCs in many districts. Although this needs to be seen in the context of State-wide electricity crisis in Maharashtra, it should also be noted that in some PHCs there is no alternative arrangement like generator for electric supply, or for providing electricity-dependent treatments at the PHCs, RHs or district hospitals. Thus inadequate improvements in certain aspects of PHCs also seem to be linked with broader systemic constraints.



XI.

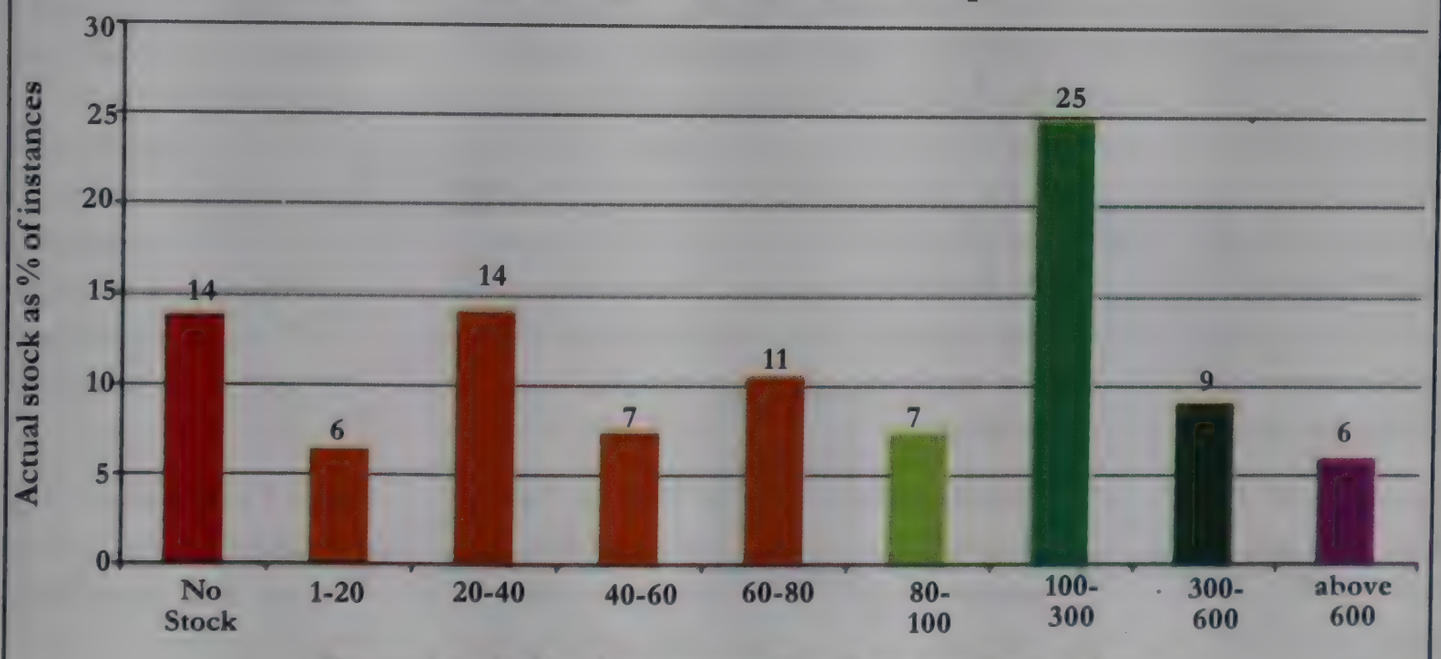
Availability of Essential Medicines in Primary Health Centres (PHCs)

During the third round of Community based monitoring, information regarding the availability of 10 essential medicines from 43 PHCs was collected from the five districts where CBM is being implemented. The list of 10 most essential medicines which are being monitored includes Paracetamol tablet and syrup, ASV Injection for snake bites, Methergine Injection to control post delivery bleeding, injection T.T., antibiotics (Amoxycillin capsule, Septran tablet and syrup, Metronidazole tablet) and antifungal Fluconazole tablet.

As per Maharashtra state Government policy, every PHC should have medicine stock which would suffice for a period of 3 months, implying that supply has to be continuous and adequate. For the purpose of this study, this 3-months requirement was used as the standard indicator. Stock showing availability less than 60% of 3 months requirement is categorized as 'stock deficiency', stock which shows availability more than 600% of the 3 months requirement is categorized as 'problematic excess' and stock level between 60% to 600% of the 3 months requirement is considered to be 'satisfactory' level of stock.

Graph no. 14 shows that 52% of the instances studied revealed satisfactory medicine stock (60% to 600%). In 42% instances medicine stock was not adequate (0% to 60%) and as a sub-set of this, in 14% instances revealed zero availability. On the other hand in 11%

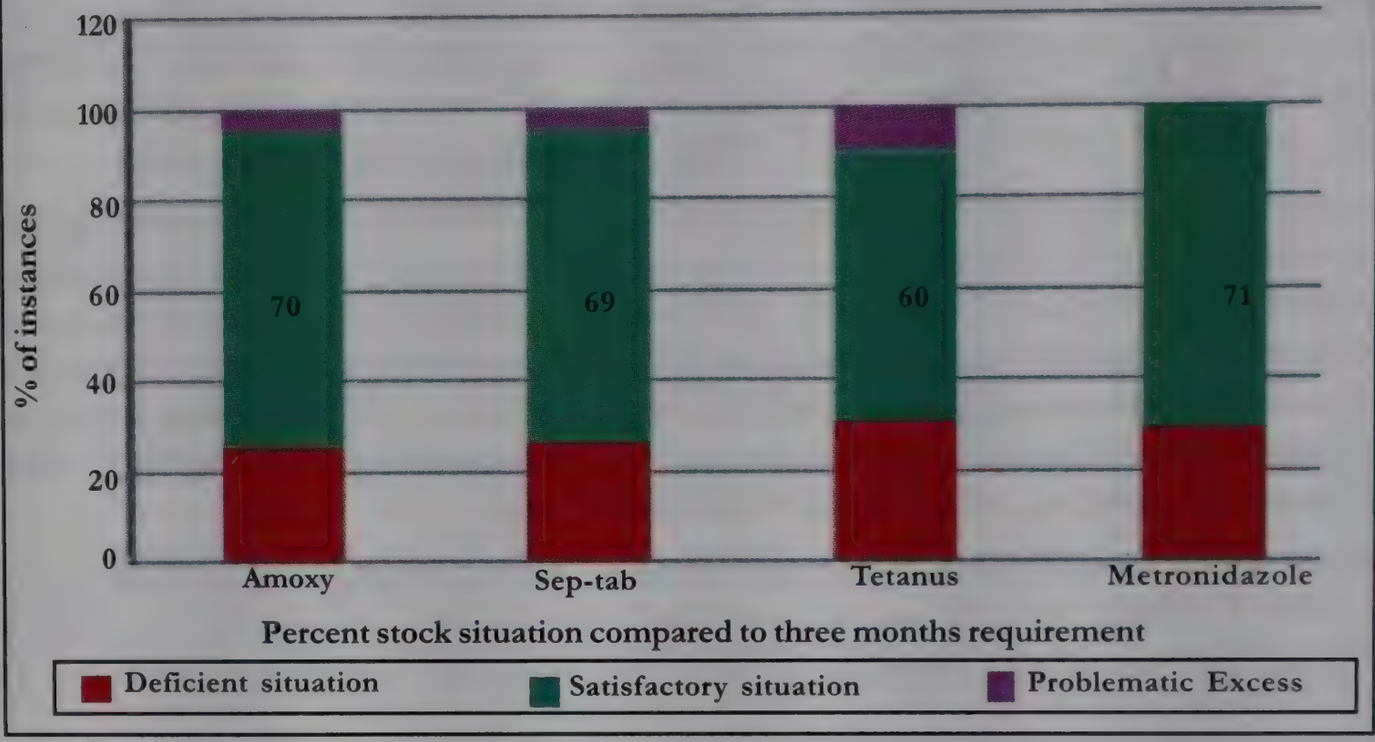
Graph 14: Overall availability of medicines in PHCs, in terms of % of instances, as compared to 3 months requirement



instances medicine stock was adequate for a period of more than a year and a half (above 600%). Such widespread deficiency as well as problematic excess of medicines is questionable.

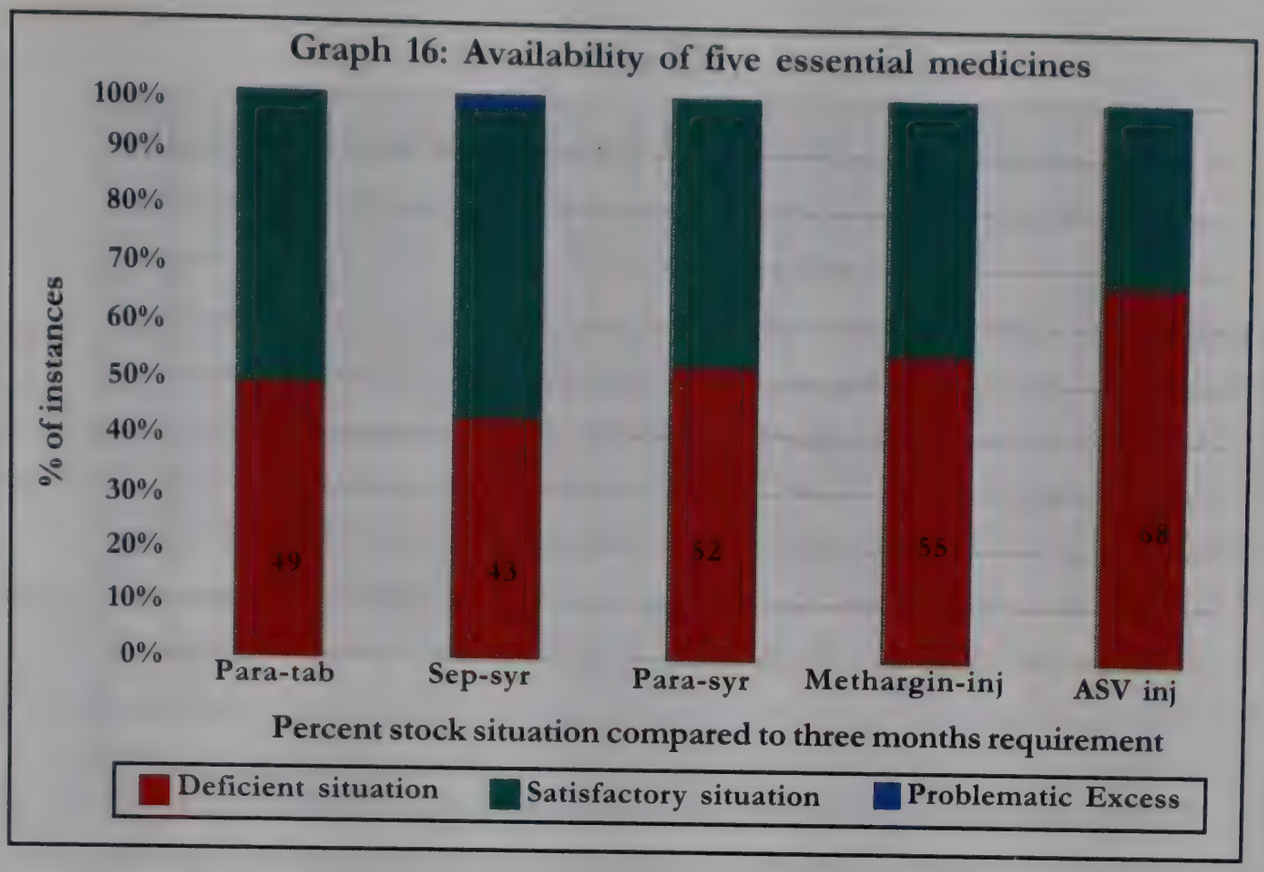
It can be seen from Graph no. 15 that important medicines like antibiotics Amoxycillin capsule, Co-trimoxazole (Septran) tablet, Metronidazole tablet as well as Tetanus (T.T.) Injection shows stock level satisfactory in 60 % to 70% of PHCs. At the same time approximately 30% PHCs show deficiency of the same medicines.

Graph 15: Availability of certain essential medicines



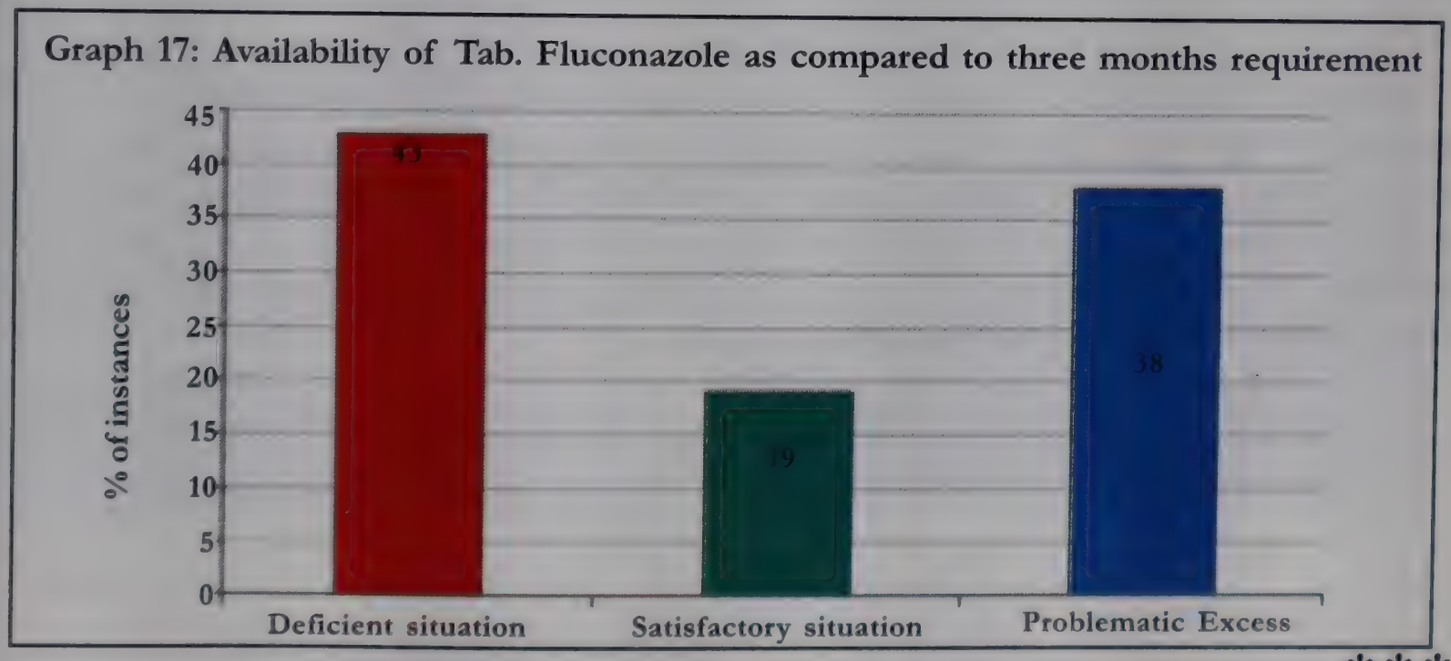
The situation appears critical regarding pediatric formulations and certain injections. Graph no. 16 shows that, stock of Co-trimoxazole (Septran) syrup, for treatment of bacterial infections (including Pneumonia) in children, and Paracetamol syrup, for treatment of fever, was inadequate in 43% and 52 % PHCs respectively. Methergine injections which are used for controlling post delivery bleeding was also inadequate in 55% of the PHCs. Keeping in view Government's emphasis on the institutional deliveries it is imperative that unavailability of essential medicines like Methargin like drugs is remedied immediately. A basic medicine like tablet Paracetamol is deficient in 49% instances. It was also observed that there is a shortage of ASV injections required for treatment of snakebites in 68% of PHCs. This is a matter of grave concern in hilly, remote and predominantly tribal areas where instances of snakebite and related deaths are very common.

Graph no. 17 shows the paradoxical situation that on one hand, tablet Fluconazole is in inadequate stock in 43% PHCs, while on the other hand it is present in problematic excess of stock in 38% PHCs. This excess is labeled as problematic excess, as stock was more than quired for a year and half.



These observations give rise to serious questions like why certain medicines are supplied in grossly excess quantity, what happens if these medicines are not dispensed and they go beyond the expiry date. Generally it seems that there is uneven and poorly managed distribution of medicines.

If this is the situation for 10 most essential medicines, State Govt has to review and restructure the whole medicine procurement and distribution system. The Government of Maharashtra needs to implement a completely transparent, accountable and effective system for medicine procurement and distribution similar to the Tamil Nadu Medical Services Corporation system at the earliest.



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XII.

'Dawandi' - State Level Newsletter for Community Based Monitoring

'Dawandi' is a Marathi term, which in Hindi may be translated as 'Dhindhora', meaning the traditional way of public announcement to the community. This quarterly news letter has been conceptualised as a medium to widely publicise various observations made during Community Based Monitoring, and also to inform readers about current events in the health sector, along with views of various stakeholders and experts related to health.

This publication includes articles about various schemes and programmes under the broad umbrella of NRHM, which people should be aware of in order to claim their rights.

It also includes opinion pieces, in order to promote discussion and involve the end-reader in the movement that is Community Based Monitoring. Exemplary positive work by field and healthcare staff, and articles that bring out their own concerns to the forefront are also talked about in the publication. Readers are given various kinds of information to enable them to be vigilant and proactive towards improving health services in their area. .

Dawandi also includes interviews with officials who are involved in the decision making process, with experienced healthcare workers and with experts from the public health arena. A unique feature of the publication is an 'open letter', which is a column in the form of a letter from a rural woman, which addresses women's health issues. Another popular element of the subscription is a photo-piece called Khichak. This section includes photographs depicting the state of public health facilities in various parts of the state where CBM is being implemented. Sometimes it depicts the poor state of infrastructure or disorganization, and at other times it displays improvements at various levels due to active efforts by citizens and those involved in the larger CBM process.

Although Dawandi is a small publication of approximately 24 pages per edition, and is published four times a year, it has become an essential part of informing the community across CBM areas in Maharashtra, and for mobilizing those who are affected along with sensitizing those who can bring about changes in the system. Presently 1500 copies are circulated across Maharashtra, reaching Village health committees to State health officials so far four issues of Dawandi have been published.

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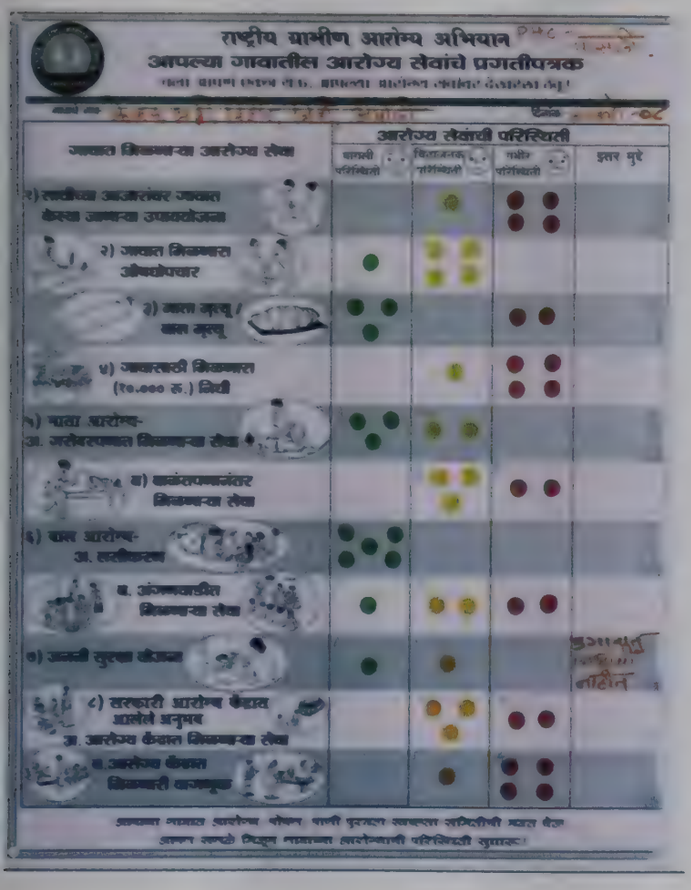
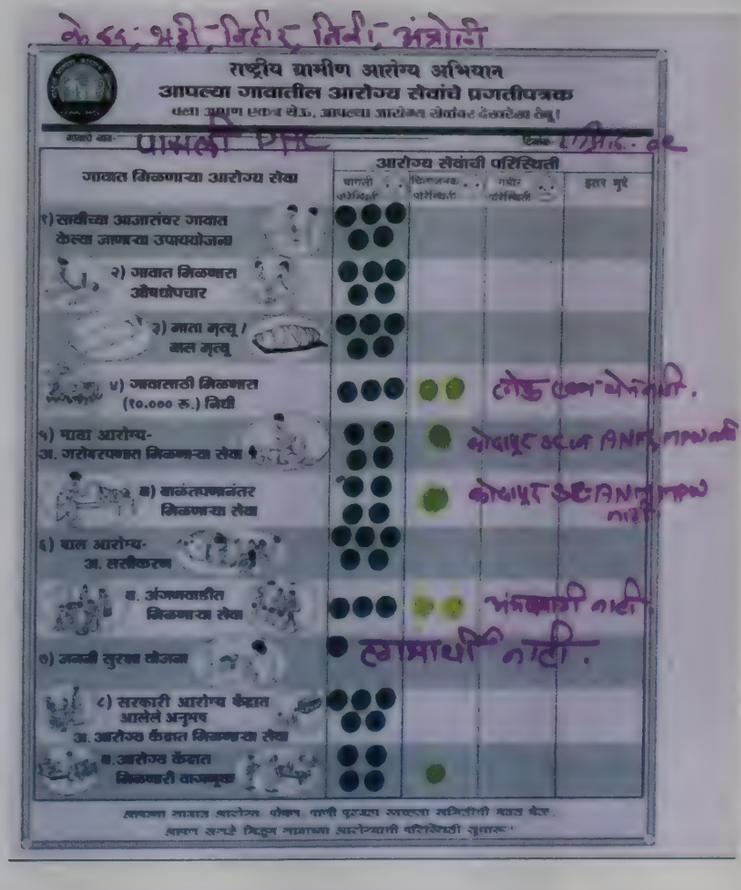
Village Health Assembly in Pune District
(Jahir Gaon Aarogya Sabha)





Change in the Report Card of five villages over two rounds of Monitoring

Positive role of media in supporting Community Based Monitoring of Health Services

Sakaal Times Thursday, August 14, 2008

NRHM to fund nursing services in rural areas

REPORTER
reporters@sakaaltimes.com

Pune: Various innovative and landmark measures are being taken under the National Rural Health Mission (NRHM) to fill up vacancies of nurses in rural ... tribal areas.

सकाळ : पुणे
मंगळवार, १७/०६/२००८

स्वयंसेवी संस्थांनी वाचला तक्रारींचा पाढा

सुधारणांचा आढावा : लोकाधारित देखरेख प्रक्रिया

They ensure ural health is n good shape

For the past few months, Kurtade from Jawahar ... district and a group of ... have been making a record of sorts. They note down the attendance of doctor at the government centre, record the number of visits the anganwadi ... and list the medi... ... cited social health activist said the government had appointed ASHAs with much fanfare, but still hadn't identified any funding for their salaries.

Simple checks can go a long way. Calendars are hung outside health centres where committee members mark the attendance of health workers, said health activist Deepak Abnave, pointing out that the black-and-white record would help introduce a sense of accountability ...

Improvement in rural health of 5 districts: Survey

TIMES NEWS NETWORK

Pune: Regular dialogue between villagers, doctors and elected representatives has reflected in improved health services in rural parts of the state.

The data was collected from 220 villages and 40 primary health centres across fifteen blocks in five districts of the state including Pune. Sathi-Cehat, a state nodal NGO, collected the information under Community Based Monitoring (CBM) of the National Rural Health Mission (NRHM).

"Nine key health services were rated by Village Health Committee members as either 'good', 'partly satisfactory' or 'bad'. Eight per cent of the services were given good ratings in phase 1, which increased to 61 per cent in phase 2 and further to 66 per cent in phase 3. Thus there has been a consistent overall improvement in village health services in the CBM covered villages in last three years," said Abhay Shukla, co-ordinator Sathi, an NGO working in health sector in Maharashtra.

Elaborating it further, Shukla said, "Under CBM, people collectively monitor activities of auxiliary nurse Midwifery and multi-purpose workers, periodically visit the PHCs and audit the availability of medicines and services, document the regularity of services and behaviour of providers, point out irregular practices, and repeatedly raise these issues with officials at various levels. All this has resulted in real improvements at the ground level."

The other four districts covered are Amravati, Nandurbar, Osmanabad and Thane.

When the community monitoring process started (phase 1: July - August 2008) it was found that there were significant gaps in services provided at the PHC and village levels across all districts.

"Based on this observation, further activities such as the preparation and display of report cards, dialoguing with health service providers and officials in various committees, presentation of problems regarding public health services through public hearing and publicising some of the observations through media was done," said Shukla.

'Widen scope of CBM to water, food security'

To widen the ambit of community based monitoring (CBM), Sathi-Cehat has given a proposal to the Planning Commission to bring CBM in other core issues like water and food security. "Considering the progress made by CBM in areas of health in rural parts of the state, integrating water and food security along with health under CBM will definitely go a long way in providing holistic care. We have already submitted the plan to this effect to the Planning Commission," said Shukla. TNN

... in state reviewed

Sakal Times | Thursday, May 13, 2010

"Representatives of gram panchayats, NGOs and villagers form the main part of the monitoring and planning committees at PHCs. Health report cards, where people ... grade health services ..."

... people. They prepare health report cards on the basis for all 11 services offered and rank the PHCs accordingly," he said.

Choudhary said that the NRHM is steadily progressing and one of the factors for this in Maharashtra was the CBM, where pressure and dialogues have worked in making the health service efficient. "The government will definitely work on improving the facilities further. CBM will soon be taken up in seven more ... in the state," said Choudhary.

The Indian **EXPRESS** 18/8/08

Villagers give poor marks to health services

Report card: thumbs up only to child immunisation and mater...

People's participation improves district healthcare

REPORTER
reporters@sakaaltimes.com

Pune: Pune district has recorded the highest rise in the quality of rural health services among five representative districts of Maharashtra, after the community based monitoring (CBM) of the National Rural Health Mission was launched.

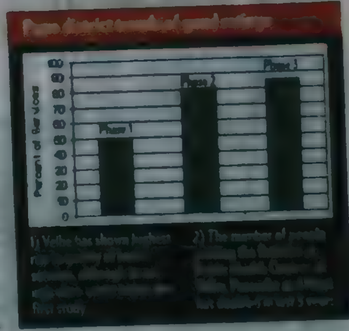
Abhay Shukla, Coordinator for NRHM-related activities of NGO SATHI (Support for Advocacy and Training to Health Initiatives) said, "The concept of CBM has to be extended for better quality health services."

The CBM was started in 2007 in 220 villages 5 districts of the state, Amaravati, Nandurbar, Osmanabad, Pune and Thane. Villages from three blocks in Pune district, Velhe, Purandar and Khed were under study. Three rounds of data collection were carried out in July 2007, March 2009 and October 2009. The number of health services that received highest rating has gone up from 49 percent to 85 percent, a rise of 36 percent.

For CBM, the health committee of a particular village meets every three months and puts forward the data collected by its members about ratings of the health services. For each functioning three basic ratings have been created: Good, Partly Satisfactory, Bad. Members of the health committee regularly rate things like basic treatment, ante-natal and post-natal care, immunisation frequency and availability of medicines.

"Some of the positive changes that took place were, nurses started going to Public Health Centres regularly. Overall quality of health services improved. Even the quality of meal served at the anganwadis improved drastically as they had been brought under CBM. This kind of monitoring worked because it involved people themselves," said Shukla. "Such monitoring should be expanded to all other services which are in bad shape due to inefficiency and corruption," he added.

Shukla further said, "CBM is the system in which common villagers have brought in changes in the system. It is the only system that is people-centric, while others are designed with government machinery at its centre."

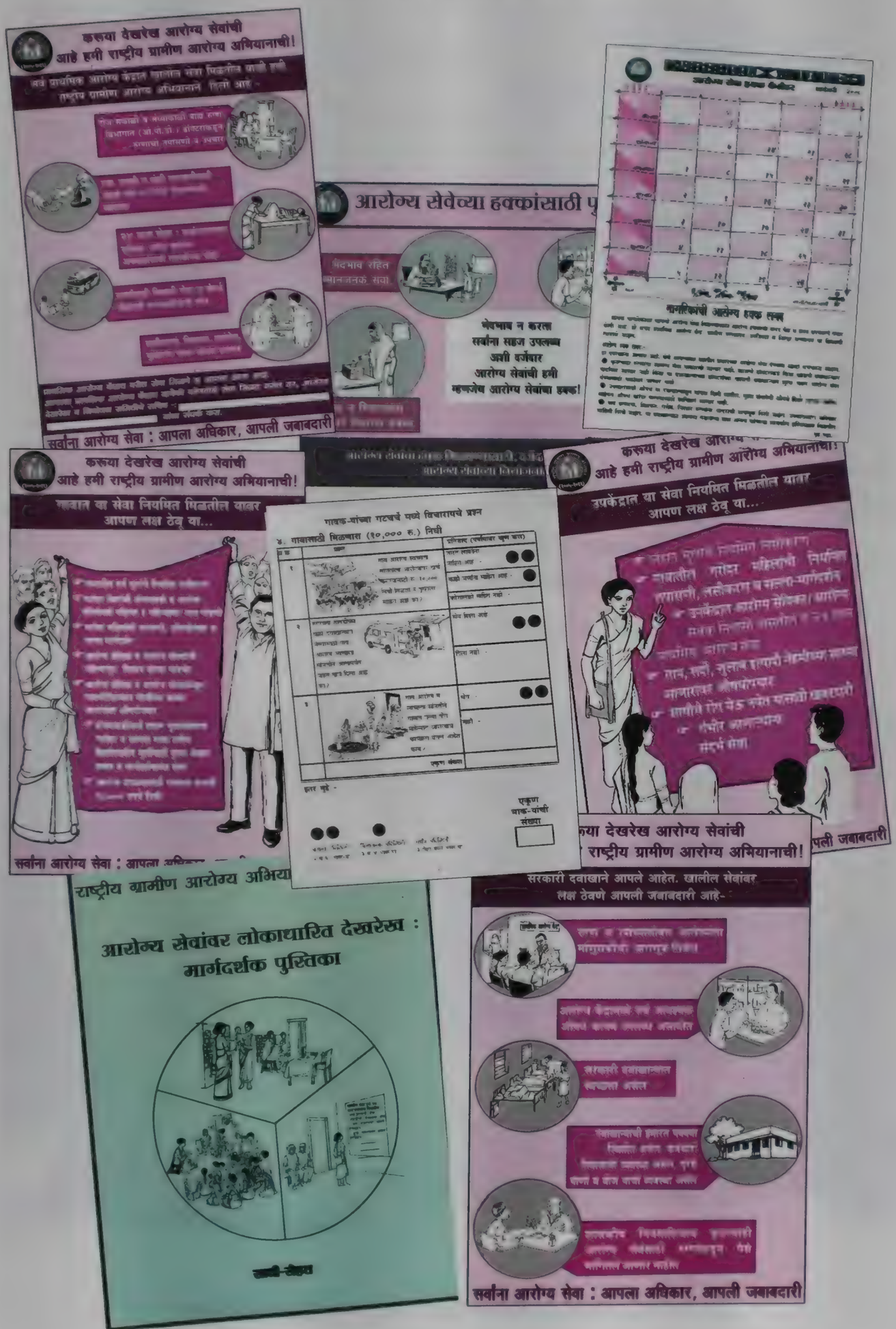


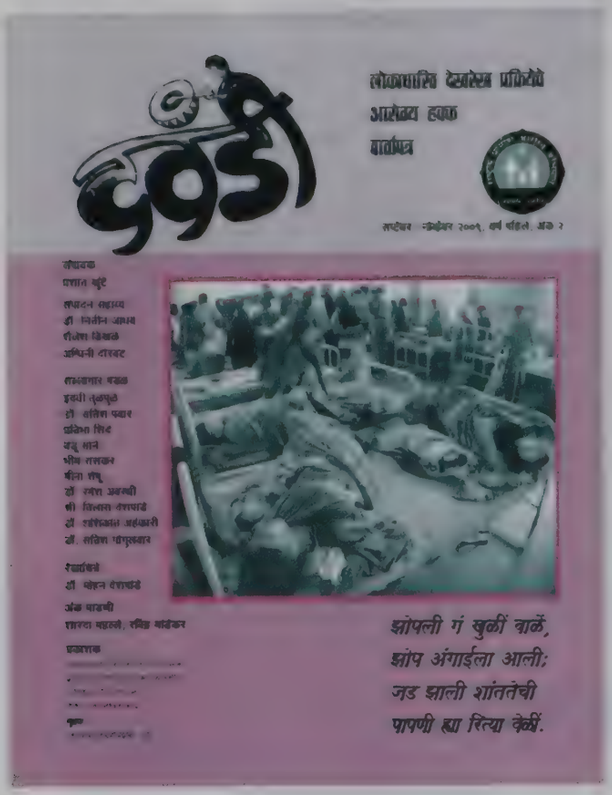
ग्रामीण रुग्णांचा 'खासगी' टाहो

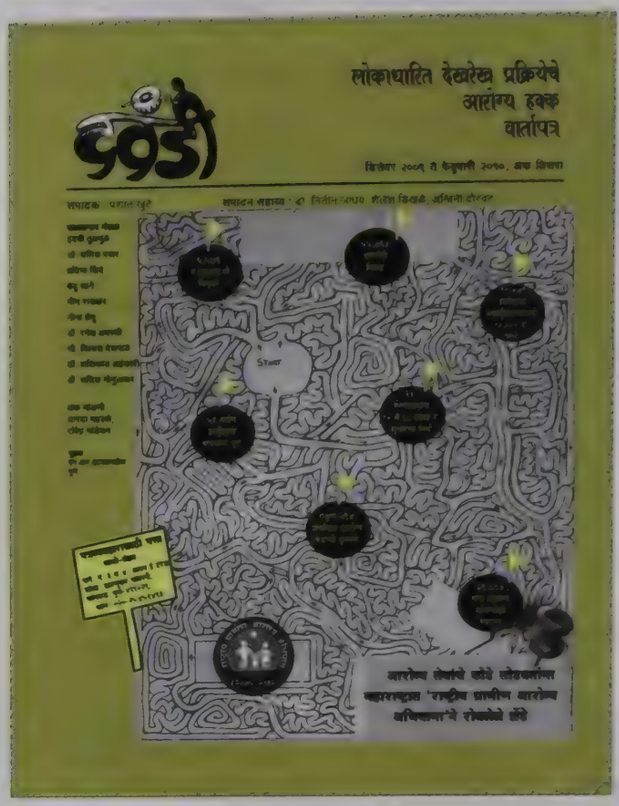
...च्या आरोग्याचे गाऱ्हाणेयसेवा अत्यवस्थ : १९४ वैद्यकीय अधिकाऱ्यांपैकी ४० कार्यरत

४० वैद्यकीय अधिकारीच कार्यरत?

Orientation & Awareness Material







'Dawandi' State level Newsletter for Community Based Monitoring

District level public hearing in Nandurbar

XIII.
Summary of Innovations and Positive Processes

New forms of Community mobilization on health

Given the fact that there is a power structure operative within each community and that the voices of the powerful within the community may substitute for the voice of the entire community, a challenge for the CBM process was to secure participation from less vocal sections of the village. Adequate precaution was taken in designing the programme itself so that the risk of 'substitution' could be mitigated, e.g. group discussions were held in the Dalit or the Adivasi hamlets and there was a separate group discussion with the women in the villages. Along with this, in a District like Thane, a wider community mobilization strategy (see section IV. a) was used very effectively which definitely energized and enthused a number of people and facilitated collective community action for health. It is worth noting that these local innovations often took place in areas where Peoples organisations (Sanghatanas) are active.

Involving Panchayat Raj Institution members in monitoring

In the spirit of decentralization, NRHM calls for PRIs from village to district level to be given ownership of the public health delivery system, across their respective areas of responsibility. In the framework of NRHM, it has been mentioned time and again that to monitor the performance of health services, people through their elected representatives at the local level should actually own, plan and administer the Public Health services.

The CBM framework explicitly mandates the key role of PRI representatives in community monitoring. The Panchayat's role in community based monitoring is manifold, in fact PRIs are a key stakeholder in this process. Unfortunately most Panchayats in Maharashtra today do not see health services as their mandate, this has been a general trend that has been observed during implementation of the project. However in Velhe Block of Pune district, some of the PRI VHSC members took an active interest in the programme.

Activating Panchayats -

One of the innovative strategies of involving PRI representatives in the process of monitoring was making them aware about the political impact that could be achieved through the process monitoring. This strategy has been effectively followed in a few pilot districts of Maharashtra. One such experience has been documented in Velhe Block of Pune District. Karyakartas of the block nodal NGO have managed to mobilize PRI members quite effectively to play an active role in VHSCs, to the extent that such a mobilization was largely unseen in any other pilot district of Maharashtra. Panchayat members, even the less active ones, have to be responsive to people and also try to understand what people want. Political importance of taking credit for making the Health system 'function' through community based monitoring would not be ignored by any elected representative. Keeping in mind this simple logic, representatives of the implementing organisation had meetings with the Sarpanchs and PRI representative in this pilot block, and managed to impress upon them that better health services from the Government's Health system could only reflect well on him/her during the next election. This led to some Panchayat members taking a keen interest in the process of monitoring. Many of them have attended the VHSC trainings and also accompanied the facilitators for conducting the FGDs and village level meetings. It is important to understand that in no other pilot district Panchayat members took such a keen interest in this process. According to a block coordinator, it has been possible owing to the nature of relationship that the facilitating agency had developed with Panchayats over the years. It acquires a special significance since Panchayats are supposed to be key stakeholders in this process.

The story of 'Cureta'- In Pune District, at least 15 Anganwadis were instructed by ICDS Department to buy a Homeopathic remedy for malnutrition called "Cureta". The manufacturers have claimed that it can lead to weight gain in malnourished children within 2 months . Several Anganwadi workers in Purandar block bought this medicine from the village untied funds, in one Anganwadi six thousand rupees were spent on buying "Cureta", ironically the price at which it is sold to Anganwadis is almost double of its MRP. After active intervention from a local Panchayat member and the NGOs involved in the community monitoring process, this gross misuse of untied fund was stopped. Certain Anganwadi workers actually returned money to the village untied fund, which had been inappropriately spent on buying 'Cureta'.

In the pilot phase, limited headway was made regarding concrete involvement of PRI members in community monitoring. However in the subsequent period, there has been a gradual increase in their involvement in CBM processes. Some strategies which were consciously adopted to promote such involvement include repeated follow up by implementing NGOs to ensure PRI member participation in committee meetings, and appointing PRI members as panelists in various Jan Sunwais. As a result of various efforts, now PRI members

in most blocks have become reasonably active in CBM processes at village and PHC level, and in some areas at block and district levels.

For example in Pune district, within the Village health committees, sub-groups have been formed to monitor specific services such as Anganwadis, school health services, functioning of sub-centres etc. Each subgroup includes both a Panchayat member as well as an NGO / CBO representative. The activities of these sub-groups entrusted with specific responsibilities have significantly increased the involvement of PRI members.

Drawing Public Health functionaries into the monitoring process -

As would be expected, initially health functionaries perceived this programme as an imposition of another top-down initiative. However in some areas the implementing organisation took special efforts to ensure synergy between community and health functionaries. Such a strategy is necessary to expedite changes in the functioning of the Public Health system.

PHC Medical Officer visits individual CBM villages in Purandar for 'Jahir Arogya Sabha' (Public Health Assembly)

In Malshiras and Parinche PHC areas, MOs have attended a series of village level meetings as part of the CBM process. In these meetings, a number of issues related to functioning of the PHC and performance of the outreach functionaries came up. In these participatory exercises, people have expressed their most immediate health needs. These meetings have also helped people in understanding roles and responsibilities of various providers in the health care system. At the same time, this platform helped functionaries in explaining the specific constraints under which they are working. One change that has been observed after these meetings is the change in attitude of the outreach functionaries. At the same time many functionaries have expressed that they are receiving better cooperation from people in the villages after these 'Jahir Arogya Sabhas'.

Though innovations during the processes of CBM are elaborated throughout the report under specific headings, it is desirable to summarise these innovations in a concise form here. These innovations were made possible because of the flexibility that the pilot project has offered to implementers at the district level, and exemplify how the CBM process can be made to work better in specific contexts or in the face of certain barriers. Similarly it should also be kept in mind that several of the organisations implementing this project had previous experience of monitoring health services or community mobilisation and dialogue around health issues. This previous experience has also allowed them to adapt and improve monitoring processes keeping in view the specific local context and sociopolitical settings.

Brief summary of key innovations in CBM process in Maharashtra

- As mentioned earlier, **specially designed pictorial VHSC tools** were used in Thane, Nandurbar and Amravati districts keeping in mind the tribal population and lower literacy levels. This has helped illiterate or functionally literate person to understand the monitoring questions. Based on the positive experience of the pictorial tools, now these are being used in all districts.
- Village and PHC **report cards were published in poster format and publicly displayed** for greater accountability.
- Design at state level and use of **Village health services calendar** in some districts
- **'Arogya Jagruti Divas'** organised in villages of Thane district, with mass participation and community mobilization followed by data collection and report card preparation
- **Block level conventions** with mass participation organised with multi-stakeholder dialogue, at an early stage of the process in blocks in Thane district
- **'Jahir Arogya Sabhas'** organised at village level in Purandar block with participation of the PHC medical officer, Panchayat representatives and community members
- **State level convention on community monitoring** organised in March 08 with participation of all concerned PHC medical officers, Taluka Medical officers, DHOs or representatives, all Block and District nodal NGOs and State nodal NGO representatives, Secretary- Family Welfare, NRHM Mission director, officials from Directorate of Health Services for comprehensive mid-term review and planning of CBM at state level
- Appointment of **State Media consultant and block level media fellowships** to ensure adequate media coverage at various levels.

Participation of the People's organisations (Sanghatanas) in the entire CBM process in Maharashtra is a major highlight of the activities in the state. Two POs were block nodal agencies in Thane and two POs were block nodal organisations in Nandurbar district. It is worth mentioning here that many of the observed innovations took place in areas where POs are active, because some of the earliest experiments in the Maharashtra on rights based mobilization of community on health issues had taken place in these areas.

Specially designed publications for less educated community members

At the initiation of this project, a range of awareness material and manuals were prepared at the National level with inputs from experts, with a clear guideline that this material is a prototype which needs to be suitably adapted at the State level keeping in view the local context and sensitivity. Obviously a range of adaptations were made in the state of Maharashtra. Publication of pictorial report cards which could be easily comprehended by

the less literate community members has definitely helped community members in less literate areas in rating the performance of public health functionaries at the village level. Elaboration on this innovation has been already mentioned in the section 'State specific adaptation and development of the training material, tools for monitoring'.

Similarly, all the posters for community mobilisation in Maharashtra were designed independently at state level, keeping in view the context in the state.

Innovations like those mentioned above are essential to communitise the monitoring agenda; such adaptations also allow implementing organisations to address the actual needs of their communities in a much better way.

Some initial positive processes

As already mentioned, making a comprehensive assessment of the Community Based Monitoring processes may be somewhat premature since this initiative is just about three years old. However we could certainly comment on certain positive trends that were observed over the period of implementation.

Recognition at the State level

Although initially response to this initiative at the State level was tentative, over time there is a growing official recognition to the process of community monitoring.

Maharashtra was the first state in the country to include the Community based monitoring component of NRHM in the state PIP (Project Implementation Plan), it was included in the PIP for 2008-09. Now in the scaled up phase (PIP 2009-10 and 2010-11) this activity is being extended to eight more districts of the state apart from the already existing five pilot districts, thus covering a total of 13 districts.

It is worth mentioning that whenever the state nodal NGO has requested the State officials to help with specific facilitation of the CBM activities at the district level, they have done so promptly. For example, some DHOs initially declined to attend important events planned during the course of implementation of CBM like the Jan Sunwais, however specific instructions were issued by the state level officials for DHOs and other functionaries to attend these events and be responsive.

Behavior Change and increase in accountability

One thing that has been unequivocally stated by all implementing organisations is a definite change in the attitude of many of the outreach functionaries and improved local dialogue. While this has been noted elsewhere in this report, a few of the illustrative examples are as follows-

a. In Akkalkuwa block of the Nandurbar District, findings from the group discussion and village level meetings are shared in the larger village level meetings so that issues become known to all community members, particularly women in the villages. While findings are gathered from the predesigned activity of village level meetings with women, according to the Block Coordinator Sanjay Mahajan, when they adopted a strategy of enabling women to speak in presence of ANM, this has contributed to improved response from ANMs because women give very clear feedback about the services that ANM is providing.

b. According to Ranjana Kanhere, district coordinator Nandurbar, whenever implementing organisations have requested PHC MOs to organize a meeting in the PHC they have cooperated and shown willingness to understand community perception about the Health services. This, according to her, is a significant change compared to the pre CBM era.

c. In Dahanu block of Thane district, some ANMs and MPWs are approaching VHSC members to contribute to planning village level health activities.

d. In Thane district there were two specific instances in separate blocks, where the issue of PHC doctors illegally charging for services was raised in PHC level Jan sunwais. In both cases, such illegal charging has now stopped. In one case, a 'Donation box' kept by the PHC doctor to collect money was converted into a 'Complaint box'!

e. In Osmanabad some ANMs, MPWS and AWWs have started sharing their programmes with the VHSC members and have also approached the District coordinator to share their difficulties.

Some changes at the community level

The sense of ownership of Public Health services has improved in the community. As one of the block coordinators says " People have a growing sense that their opinions about the public health department, have some say in planning and functioning of outreach and PHC services". Another interesting point that emerged from discussion is how any form of empowerment has a spill over effect on the other livelihood issues. The block coordinator narrated an instance where people voluntarily gheraoed the PDS shop and demanded a supply list from owner of the shop; it is worth noting that many people who initiated this activity are also closely associated with the CBM. Similarly people have begun demanding from the local officials, better implementation of the Employment Guarantee Scheme.

Particularly in districts like Osmanabad, Nandurbar and Pune what was especially striking is the participation of women in the community monitoring activities. It has been a general experience of the block coordinators that responses from women in the village indeed depict a more authentic picture of the local Public Health services than men. Perhaps it has to do with greater utilization of PHC services by women compared to men, who tend to have more access to private health services.

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XIV.

Challenges and Critical Aspects of Processes

Facilitation of community based monitoring is an inherently complex process since the quality of services and responsiveness of health care providers comes under the direct scrutiny of ordinary community members. The traditional vertical power relationship between educated, articulate and officially anchored health care providers on one hand, and often less educated, generally less influential village community members on the other hand, is challenged. Driven by the spirit of democratization of Public institutions, an attempt is made to move towards some degree of equalization of power in this traditionally hierarchical and unequal relationship. Such a process of systematically and regularly demanding accountability is not expected to proceed without some degree of resistance or at least reluctance on behalf of those who are expected to allow themselves to be held accountable.

Hence the issuance of GRs or similar written communication by the state authorities, though important and necessary, will in itself not be sufficient to facilitate the process of monitoring. State authorities need to initiate processes for institutional acceptance and responsiveness by health care providers at various levels for this programme. This would require continuous and multiple interventions at all levels of the Public health system ranging from the State to Sub-centre level. Keeping this in mind, the experiences during the first three years may not be sufficient to draw conclusions about successes and failures of community monitoring; the analysis of challenges mentioned here should be regarded as illustrative, not conclusive. In the following paragraphs the attempt is to briefly outline challenges that are observed over the period of last three years of implementing the pilot project, under the following headings:

Critical analysis of some aspects of the CBM process

A. Interaction between the civil society nodal organisations and the Health Department at all levels, ranging from the State health department to the PHC.

B. Community level interactions between implementing civil society organisations and people

C. Interaction between block, district, state and national implementing NGOs.

D. Convergence issues and Community Based Monitoring.

E. Challenges observed during the selection of nodal NGOs for the expansion phase and key bottlenecks in scaling up.

A. Interaction between the civil society nodal organisations and the Health Department at all levels, ranging from the State health department to the PHC.

i. Response at the state level-

- Especially in the initial phase, certain individual senior officers in NRHM have taken definite initiative, and have been actively involved in developing the entire CBM process. It should be recognized that without such proactive, positive initiative, the CBM process in Maharashtra would not have moved ahead in the manner that it has. However, the *departmental formal decision making process tends to be quite time consuming.* Key decisions are quite centralized with apex officials which may contribute to delays. For example *the issuing of the Government Orders for formation of PHC, Block and District monitoring and planning committees took six months despite relentless, persistent follow up*

- State level officials' ownership and involvement in CBM may also need renewal and reinforcement, due to periodic rotation of officials. State level officials may take some time to be fully oriented about the CBM process, including appreciating its unique character of 'creative conflict' and the need for it to remain somewhat autonomous from the Health department compared to routine programme implementation.

- Centre-to-State official information sharing about this pilot project was particularly weak in the initial stages. Very often representatives of the State nodal NGO have played the main role in sharing information about CBM with the State officials.

- At the National level very often it is reiterated that 'Health is State subject', however it was noticed that for certain State specific decisions related to CBM, which are by no means beyond the purview of the state government, the State officials tended to rely on guidelines from the National level.

ii. Response at the District level-

- Response and support to this initiative at district level was mainly 'evoked' through GOs and similar orders from the State level. At the initial stages there was poor institutional recognition of the CbM process at district level, and it was generally identified more as an NGO initiative, rather than as a major component of NRHM. However the situation has improved after the first State level convention and the State culmination and review workshop, in these events it has been repeatedly stressed that Community Based Monitoring is an important component of NRHM and it should be taken seriously.

- In one district, the DHO was upset about the negative media reports and strongly contested the findings that were mentioned in it. Although it has not resulted in a

backlash, the implementing agencies were forced to rethink the strategy of approaching the media. Clearly district level media advocacy is a powerful tool but one-sided or sensationalised reporting by media may lead to alienation of certain officials.

- Frequent transfers of the DHOs and DPMs in specific pilot districts has also led to weak institutional memory of this process there.

iii. Response and observations at the PHC level -

- Many outreach functionaries tended to perceive this project as the imposition of another top-down initiative by the Government. Initially, barring exception of certain individual functionaries, generally there has been reluctant participation and cooperation of Health department functionaries in the processes of monitoring at the village level, like formation of monitoring committees, group discussions with community and women, training of VHSCs etc. However after some confidence building by the block and district coordinators, many functionaries have started engaging with the process.

B. Community level interactions between implementing civil society organisations and people

Two clear patterns have been observed-

In the areas where People's Organisations (POs) are implementing the project:

- Many of the innovations introduced to the process of monitoring took place in areas where Peoples organisations ('Sanghatanas') are involved, particularly in Thane district of Maharashtra. The more autonomous, flexible mode of functioning of POs and their strong grassroots base has contributed to this. However the level of systematic information collection and carrying out of defined activities as per timeline has varied from one PO to another.

- To keep things in perspective, it should be noted that one of the Peoples Organisations in Thane was better poised to introduce innovations because it has a significant history of community level rights based work on health issues. At the same time it would be important to clearly understand why Peoples Organisations are in a better position to facilitate evolution of an effective model of Community Monitoring. Community members require some consciousness of rights before they can respond to the complex agenda of community monitoring of health services. This socio-political consciousness has already been nurtured in the community by Peoples organisations on a range of livelihood issues. It has created a foundation for building up community health initiatives, including community monitoring of health services.

Related issues -

- The traditional relationship between POs and the State is antagonistic, and any move to give formal space to POs may tend to be opposed by officials, particularly by the local bureaucracy which is continuously critiqued and pressurized by the POs. This dynamics was observed in certain districts of Maharashtra where POs are involved in implementation of Community based monitoring.
- Mobilisation by POs may accentuate political polarization at the village level, leading to situations where there may be strong participation from several hamlets and villages, but politically inspired resistance in few other areas.
- At the implementation level, everywhere in the state we do not have POs, and not every existing PO might be interested in taking health on their agenda. However, wherever they have a presence, POs could play a definite role in creating strongly community-rooted models of monitoring.

In the areas where an NGO is implementing the project:

- Generally NGOs have done quite systematic 'copy book implementation' of the process in the areas where they have been involved in CBM. Further, some project implementing block NGOs have come up with innovations, such as managing to involve PRI members in this process. Again there is significant variation amongst the NGOs.
- In terms of preparedness and capacity to implement the monitoring processes in the true spirit of Community Based Monitoring, there have been some variations in the NGO responses. Organisations with a background of organizing Jan Sunwais on Health issues were better placed to carry out such mobilisation activities.

Keeping this in mind, one potential challenge that may emerge during the generalised phase relates to identifying NGOs which would be more appropriate to organise CBM activities. When the district implementing organisations were selected, organisations already involved in Health rights activities were the natural choice for the State mentoring team. These organisations were selected based on their past experience of involvement in rights based work and also community level presence. However in the scaled up phase when CBM would be extended to several new districts, there may be challenges in identifying experienced and competent organisations for CBM.

C. Interaction between block, district, state and national implementing NGOs-

Programmatic interaction-

- It has been observed that at the block level small organisations and POs with previous experience of working on health rights issues were often able to give more focused attention to this project than certain larger organisations handling multiple projects.
- As already mentioned, in the structure of the pilot phase various capacity building

processes like trainings are in a cascading framework (viz - State ToT' District ToT' VHSC training and so on). It was assumed that because of this arrangement, in every district a pool of resource persons would be created to conduct trainings at various levels of the monitoring committees within the district. However in reality on some occasions, resource persons from the State nodal NGO were required to visit districts to conduct training sessions till the block level. It seems that the single state level ToT or District level ToT may not be sufficient to ensure that the cascade model of training works appropriately. More sustained training inputs would be required.

Administrative interaction-

Significant delays in releasing certain instalments from the national level in the pilot phase led to delayed start of certain important activities like VHSC trainings. It has also led to delay in releasing honorarium of the block and district coordinators. Due to this, SATHI was compelled to advance some funds from the corpus of their trust.

D. Convergence issues and Community Based Monitoring

Although the process of community based monitoring of health services is often interpreted to be linked with health care, the ambit of CBM is somewhat wider where for example the functioning of the Anganwadis is also covered. Anganwadis have important objectives with respect to nutrition, health and preschool education of under-6 children. In some of the CBM districts like Nandurbar and Amaravati, where malnutrition and related morbidity has been reported for more than a decade now, one of the key issues that has been reported during last three years, over and again is lack of synergy between the ICDS department and the Health department. This point about the lack of synergy has been raised by District and Block nodal NGOs on various forums like Jan Sunwais and dialogue during monitoring committee meetings. However CBM has not been able to address this lack of convergence very effectively so far. Over the last 3 years of implementation of CBM, in spite of repeated documentation of poor functioning of Anganwadis, ICDS officials despite advance intimation have often preferred to stay away from events like PHC and District level Jan Sunwais. Despite repeated suggestions, ICDS officials at state level have not been involved in state level dialogues.

Issues like water supply, solid waste disposal etc. which have direct relevance for health have been raised but could also not be effectively addressed by CBM processes so far, particularly due to non-involvement of concerned officials.

E. Challenges observed during the selection of nodal organisations for the expansion phase and key bottlenecks in scaling up

As already mentioned, in the expansion phase selection process, some applicant organisations have attempted to bring political or administrative influence on the selection process and also attempted to do canvassing by attaching recommendation letters to their applications.

There is also one key contrasting feature between the pilot phase districts and districts where CBM would now be expanded. All the pilot districts were selected on the basis of known presence of specific credible civil society organisations with reasonable degree of experience of health rights work and community mobilization, often based on their involvement in earlier health rights campaign activities. In the expansion phase, though organisations were selected based on well worked out selection criteria, in some districts their capacity to implement the comprehensive rights based agenda of CBM is untested. This kind of uncertainty seems inevitable in the scaled up model of CBM.

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XV.

Possible Strategies while Further Scaling up the CBM Process

Based on the experiences of the initial three years, while further scaling up community based monitoring in Maharashtra, some of the following strategies may be kept in mind.

a. Institutional processes

- **Need for a separate and well defined process of orientation of Public Health functionaries at District and Block levels**

Unlike during the pilot phase, the health department should organize a special training of health functionaries to orient them about the processes of community monitoring.

In the pilot phase, we have noticed that during the joint trainings suggested activities for monitoring were perceived as threatening by functionaries, particularly by outreach functionaries. Probably it has something to do with trainers who have a NGO or CBO background, whose natural inclination would be probably to overlook genuine difficulties that ANM / MPW may face while doing outreach functions. Moreover the method of communicating the core content of these trainings could have been seen as an imposition of another centralised initiative to the local health functionaries. This could also be one of the important reasons for low turn out of functionaries for range of VHSC and District training on community monitoring. Their confidence building and involvement in this programme would be possible if they are given appropriate orientation about their responsibility in the monitoring process. This would also help to create a conducive atmosphere for dialogue and consultation between civil society representatives and health functionaries; however this should be done with adequate precaution without affecting the core principles of community monitoring. More importantly, the current situation which often requires state level interventions to resolve local obstacles could also be changed significantly, though need for such facilitation would not vanish completely.

- **Inclusion of community based planning component in the District Health Plans**

Although this is not a new idea, during the pilot phase while designing tools for monitoring and during subsequent field testing, it was realised that Districts vary widely in needs, support structure, and civil society capacities to conduct the programme. However planning for community based monitoring at local level would require a high degree of receptiveness by local officials. Wherever these possibilities exist we should ensure that community based planning component is added in the District Health Plan.

- **Concrete and fruitful involvement of PRIs-**

1. For the pilot process we have laid down a specific norm for inclusion of PRI members (SC, ST, Woman members) in various committees so that these committees are equity sensitive, let us hope that this consideration would be helpful for generalized phase and these selection criteria would be strictly followed.
2. VHSC members are not paid workers unlike the block facilitators or coordinators. However ownership of this programme is going to be with them since they are supposed to fill up the questionnaire and conduct monitoring activities at the village level. As an incentive mechanism, some funds from the village untied fund may be reserved for conducting monitoring activities at the village level.
3. For functional clarity about Community based monitoring, general and theme based trainings need to be conducted for PRI representatives especially at the village and block level.

b. Processes at the community level

Unless there is space for taking up issues of their own priority, in a manner which they find useful, no community would be interested in continuously implementing a structure of monitoring. Hence the strategy should be to encourage local innovations and to allow local models of monitoring to evolve. This has been observed very clearly in the pilot phase, in areas where people's organisations are implementing the project. Some strategies for the scaled up phase could be as follows-

- *Open trainings at the village level-* Unlike in the pilot phase, in the expansion phase apart from the VHSC members even the other community members who are interested in participating in the training sessions may be encouraged to attend. Naturally the actual responsibility of conducting the monitoring activities would be formally assigned to the VHSC members. Open trainings would help in spreading community level awareness about community monitoring.
- *Feedback to the community-* As already mentioned, one of the most effective mechanisms to ensure sustained community participation in the processes of monitoring is to highlight any consequent positive changes in the functioning of the Public Health System. That is why it should be ensured that information dissemination about steps taken by the Public Health Department to improve upon the observed deficiencies takes place at the community level. This would also help every subsequent monitoring cycle to outline outstanding issues, and give specific attention to it.
- *Ensuring full participation of the oppressed sections of the society-* obviously a village is not a homogenous entity. There are hierarchies of class, gender, caste, control over assets, political power. In the framework of community monitoring there are multiple provisions to ensure that processes of monitoring allow oppressed sections of society to voice their opinion about their experiences of functioning of the Public Health System. It is

important to be vigilant to ensure that these provisions are protected. Otherwise what we perceive as the 'voice of community' might actually be the voice of only the powerful people in the community.

c. Modifications in the technical processes of monitoring-

- *Modification in the tools-* As already mentioned, modification in tools would be necessary in the generalised phase keeping in view the experience of pilot phase. Perceptions of people about health services have significant gradations which often could not be summarized only in the form of 'Good', 'Satisfactory' or 'Unsatisfactory' ratings. There is now a provision in the questionnaire to fill up the qualitative information emerging during the group discussion or beneficiary interviews.
- *Creation of a pool of resource persons at the regional level-* CBM would now be implemented in 13 Districts of the State. Keeping in view the increased training needs in expansion phase, the process of creation of a pool of resource persons in each region has now been initiated. These resource persons would be involved in giving inputs for key events like ToTs, workshops, Jan Sunwais etc.
- *Mechanism for follow up of Jan sunwais-* As a standard method, a mechanism needs to be set up to raise unresolved issues from PHCs, Rural Hospitals and the district level Jansunwais, including addressing systemic issues at the state level.
- *Monitoring the rapid changes in the public health system-* In emerging Public private partnerships (PPPs), access of people to these services as well as quality of care, 'informal' excess charging etc. would need to be strictly monitored by the community, since non adherence to public health principles by the private sector while they engage in PPPs seems to be an emerging contentious area. However this would require significant capacity building of the monitoring committee members.
- So far, often community monitoring processes tend to attribute all the problems to the lack of motivation of the peripheral staff. However there is less reflection on the lacunae in the programme design and policy, and corruption at the higher levels. Hence there is a need to extend the concept of community based monitoring to a number of key processes of governance at higher levels of monitoring ranging from block, district to state level.

Despite all the problems that are ailing the public health system in India, the public sector is the only site of assistance for the poor. Hence it is particularly important to ensure that critical findings from community based monitoring should not become one more excuse for weakening the Public health system. There are 'decision influencers' who might want to use the findings of community monitoring to argue for abandoning public provisioning, in order to push their privatisation agenda. However *our overarching goal is to strengthen the public health system, while bringing the Public back to the centre of the Public Health System.*

Keeping in mind the current challenges facing the public health system, the positive alternative to privatisation must be communitisation of health services.

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SATHI

(**S**upport for **A**dvocacy and **T**raining to **H**ealth **I**nitiatives)

SATHI is the action-centre of Anusandhan Trust with headquarters in Pune. The SATHI team initiated its work in 1998 as an action team in CEHAT and has now evolved into an autonomous centre. The core principles of SATHI's functioning are social relevance, democratic mode of functioning, ethical conduct and social accountability.

SATHI's strategy is to contribute, as a team of pro-people health professionals, to the health movement and to foster various initiatives which promote health rights.

Presently SATHI's core areas of collaborative work are-

a) Collaborative health initiatives on health rights with like minded People's Organizations and NGOs in Maharashtra and Madhya Pradesh.

b) Fostering advocacy on patients' rights in private hospitals in Maharashtra.

c) Training on Health Rights and facilitation of Community Based Monitoring of Health Services in selected areas in Maharashtra under National Rural Health Mission.

d) Mainstreaming the method, perspective of SATHI and other like minded organizations about training of Community Health Workers, by preparing pictorial training manuals for ASHA and collaborative pilot ASHA trainings in selected areas of Maharashtra.

e) Research on areas like Health and Health care related inequities and provision of essential medicines in the public health system in Maharashtra.

f) Action research related to health advocacy.

g) Publication of relevant training and advocacy material on health issues.

Further information about SATHI may be accessed at-
www.sathicehat.org